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INTRODUCTION

A **Key Contact** can be described as a person or agency who may be contacted by a woman in need of information, referral or care after her abortion.

Key Contacts can include a range of professionals: you may be a GP, a practice nurse, a student health worker, a social worker or a counsellor, for example, and you may be approached by a woman who has had an abortion.

You may have sufficient expertise in your field to be able to assist her, or you may need to refer the woman onto another professional or agency for a variety of reasons.

Throughout this resource, the term 'patient' has been nominated to indicate a woman after an abortion. 'Patient' is interchangeable with the term 'client,' depending upon your professional background and work.

This resource has been produced by the Crisis Pregnancy Agency (CPA) and the Women's Health Programme, Irish College of General Practitioners (ICGP). It provides all the relevant information in one place so you, the service provider, can better support and help your patient.

The CPA was established in October 2001 to bring strategic focus to the issue of crisis pregnancy and to:

- Reduce the number of crisis pregnancies by the provision of education, advice and contraceptive services
- Reduce the number of women who opt for abortion by offering services and supports which make other options more attractive

- Work with existing service providers and voluntary bodies to provide counselling and medical services after crisis pregnancy.

The Irish College of General Practitioners (ICGP) is the professional body for general practice in Ireland. Founded in 1984, its primary aim is to serve the patient and the general practitioner (GP) by encouraging and maintaining the highest standards of general medical practice. It is the recognised body for education, training and standards in general practice.

This work has been supported by a grant from the CPA. This publication is one in a series of resources developed by the CPA under the banner of 'Key Contacts' in the prevention and management of crisis pregnancy.

CONFIDENTIALITY

In all dealings with a woman who has had an abortion, it is paramount to retain, to the extent of your professional ability, the confidentiality of your patient. This is necessary to preserve the contract of care undertaken with your patient, and it is also one of the key requisites for most women who wish to access care (for any reason) after the procedure. Preservation of confidentiality is particularly relevant if a woman does not want her family members, spouse or partner to learn of her procedure. Preservation of confidentiality may also have implications for storing and

recording patient details or client notes.

HOW TO USE THIS RESOURCE

The resource is divided into 2 complementary sections for ease of use:

SECTION 1

- Contains comprehensive information on issues for your patient or client after an abortion. Important points are highlighted throughout the resource.

SECTION 2

- Contains contact details of relevant agencies and support services within Ireland. It also lists useful patient resources and a glossary of terms used throughout the resource.

DISCLAIMER

This resource provides relevant and pertinent information for you within your professional capacity. **It is not an exhaustive source of information, nor is it a substitute for obtaining professional legal or medical advice (in appropriate circumstances).** Where a person or agency is faced with a particular issue that may require independent professional advice, it should be sought.

Content was considered correct at the time of going to print (April 2007).

SECTION ONE

BACKGROUND

In 2005, 5,585 women with addresses in the Republic of Ireland had abortions in clinics in England and Wales.

This represents a welcome decrease in figures from the previous year, but the numbers provided must be presumed conservative, as they were gathered from women who provided addresses in Ireland **only**. Anecdotal reports suggest that Irish women are availing of abortions in countries other than Great Britain, particularly The Netherlands, Spain and Belgium. Data pertaining to the numbers of Irish women presenting to such clinics outside Great Britain is difficult to ascertain.

From a medical perspective, more than a third (35.8%) of Irish GPs surveyed in 2004 had seen a woman with a crisis pregnancy in the previous month. Although most of these women gave birth, a significant proportion opted to terminate their pregnancies.

Thus, abortion is a real and current factor in Irish society. Irish women travel abroad to access abortions, and usually return home as quickly as possible after their procedures. As with any medical intervention, there is commonly a need for follow-up care. Despite recommendations that all women avail of routine medical check-ups after their abortions, discussions with Irish service providers indicate that only about 10% of Irish women avail of such examinations upon returning home.

THE LAW ON ABORTION IN IRELAND

Abortion is illegal in Ireland except where there is a real and substantial risk to the life of the mother. This includes the risk of suicide.

The Regulation of Information (Services Outside of the State for Termination of Pregnancies) Act, 1995 makes it clear that it is legal within the Republic of Ireland to provide information and contact details about agencies overseas who provide abortion services provided this information is given in the context of non-directive counselling by;

- GPs and other doctors
- Crisis pregnancy counselling agencies
- Individual counsellors giving crisis pregnancy support.

It is fully legal to provide care for a woman in Ireland after her abortion.

THE LAW ON ABORTION IN NORTHERN IRELAND

As in the Republic of Ireland, abortion in Northern Ireland is also illegal and is governed by the Offences Against the Person Act 1861, the Criminal Justice Act (Northern Ireland) 1945, the Bourne Judgment case law (1939) and the Common Law. Legislation provides that abortion in Northern Ireland is only permitted where it is necessary to save the life of the mother or where continuation of the pregnancy would involve risk of serious injury to the mother's physical or mental health.

THE LAW ON ABORTION IN GREAT BRITAIN

The governing legislation on abortion in Great Britain is the Abortion Act 1967 as amended by the Human Fertilisation and Embryology Act (HFEA) 1990. Abortion is legal in Great Britain if two doctors decide in good faith that a particular pregnancy is associated with factors that satisfy one or more of five grounds specified in the Abortion Act 1967 and Section 37 of the Human Fertilisation and Embryology Act 1990.

CRISIS PREGNANCY AND ABORTION

AN OVERVIEW OF THE CURRENT SITUATION IN IRELAND

The crude birth rate in Ireland currently stands at 14.8 per 1,000 of the population. In Ireland in 2005, the total number of births was 61,042. The number of Irish women having abortions in the UK in the same period was 5,585. This represents approximately 9 abortions for every 1,000 births in the Republic of Ireland, although abortion statistics for Irish women are assumed to be incomplete (UK NSO 2005).

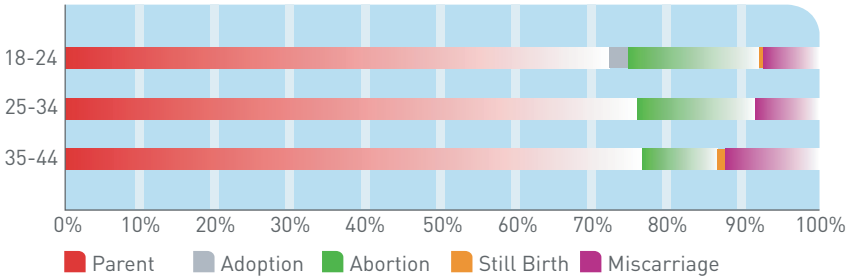
In a 2004 CPA research study of 3,317 Irish persons aged between 18 and 45 years, 12% of all pregnancies experienced were cited as crisis pregnancies. Twenty-eight percent (28%) of female respondents with experiences of pregnancy over their lifetimes, defined at least one pregnancy experience as a crisis pregnancy.

This study found that, of the 245 women who had crisis pregnancies, abortion was the outcome for 15% thereof. The average age of women experiencing their first crisis pregnancies was 23.4 years (ICCP CPA Research Report 7).

Abortions most commonly occur in the 18 to 24 year old age group. Abortion is more likely to be an outcome of pregnancy for those under 24 years of age and for women over 40 years of age.

A recent survey of GPs in Ireland found that 92.9% provide counselling for crisis pregnancy. Furthermore, 88.3% of GPs are willing to refer women experiencing crisis pregnancies to other agencies, and the majority will refer to more than one agency (Women’s Health Services in General Practice, ICGP 2006). In Ireland, the CPA funds several organisations to provide free crisis pregnancy counselling throughout the country.

FIGURE 1: CRISIS PREGNANCY OUTCOMES BY AGE OF CRISIS PREGNANCY (ISSHR 2006)



ABORTION METHODS AND ROUTINE CLINIC PROCEDURES

ABORTION METHODS

FIRST TRIMESTER

A medical abortion is a combination of drugs used to induce a miscarriage (usually oral Mifepristone, followed by vaginal Prostaglandins 48 hours later). This method is not commonly chosen by Irish women because it requires more than one visit to the clinic over a period of 3-4 days.

SURGICAL TERMINATION

The contents of the uterus can be emptied by suction up to 12-14 weeks into pregnancy. This procedure is well tolerated with local anaesthetic or conscious sedation up to 11 weeks into pregnancy. Local anaesthetic reduces the relative risk of the procedure, but after 11 weeks' gestation, general anaesthetic is usually used. Surgical termination, in general, is not advisable before 7 weeks' gestation because there is a risk of missing the gestational sac, resulting in an unsuccessful procedure.

SECOND TRIMESTER

Dilatation and evacuation is the method most commonly used in the clinics accessible to Irish women. It requires an overnight stay, as it involves 2 stages. A general anaesthetic is always used.

FIGURE 2: ABORTIONS BY GESTATION – IRELAND 1975-2004 (CPA DATA 2006)

	Gestation (Weeks)			
	Under 9	9-12	13-19	20+
1975	34.2	50.7	14.1	1.0
1980	31.3	51.3	15.7	1.7
1985	32.9	48.8	15.6	2.8
1990	37.8	41.6	18.0	2.6
1991	39.5	40.2	17.9	2.4
1993	40.8	41.0	16.5	1.7
1995	39.9	40.7	16.8	2.5
1997	35.1	45.6	17.1	2.2
1999	36.5	43.4	17.5	2.6
2000	40.0	43.1	14.6	2.3
2001	41.0	43.4	13.4	2.2
2003	41.2	42.8	13.9	2.1
2004	42.1	42.1	13.8	2.0

Values are percentages; percentages are adjusted for missing data.

In the UK in 2005, 67% of abortions were performed under 10 weeks' gestation. Almost 85% of Irish women will have had their pregnancies terminated at or before 12 weeks' gestation. This data is presented in Figure 2.

MEDICAL PROCEDURES AT AN ABORTION CLINIC

Ultrasound Scanning

Most abortion clinics utilise ultrasound scanning to accurately date a pregnancy prior to the procedure and to rule out an

ectopic pregnancy, if it is suspected. For many women, this will be the first and only confirmation of gestational stage.

Blood Testing/Rhesus Prophylaxis

It is usual to have the woman's haemoglobin (blood count to screen for anaemia) and blood type (ABO/blood antibody status) established before the abortion on the day of the procedure. This allows for clinic staff members to provide rhesus prophylaxis, if deemed necessary. The woman should receive this as an intramuscular injection (usually into the deltoid muscle) before being discharged

from the clinic, having been given relevant information on the prophylaxis.

Screening for Infection

It has been recommended that, prior to an abortion and where possible, a woman should be offered screening and treatment of any pre-existing infections in the genital tract area. Chlamydia trachomatis, an STI, is an example of this type of infection. There is variation amongst UK clinics as to whether this screening is performed on a routine basis or merely offered to a client at an additional cost.

In order to minimise the incidence of pelvic infection after abortion, most women are given one of the antibiotic regimes, as listed below.

Doxycycline 100mg (orally for 7 days, commencing post-abortion)

OR

Azithromycin 1g (orally on day of abortion)

PLUS

Metronidazole 1g (rectally at time of abortion).

This regime reduces the risk of post-abortion infection and any long-term associated medical conditions, such as tubal infertility or ectopic pregnancy. If Chlamydia trachomatis is present, a significant proportion of cases will be treated with one of the aforementioned regimes.

Contraception

On the day of the abortion, a woman is counselled regarding her future methods of contraception. If appropriate, a woman will be instructed to commence use of her chosen method on that day. Condom use is recommended after an abortion in order to avoid the risk of infection.

Leaving the Clinic

Upon her discharge from the clinic, a woman will have been given antibiotics, pain relief (as necessary) and an information pack containing:

- Self-care leaflet, itemising the symptoms the woman may experience, and a list of symptoms that would make an urgent medical consultation necessary
- Telephone numbers for use in case of emergency queries.

The Royal College of Obstetricians and Gynaecologists in the UK (RCOG UK) recommends that all women obtain a medical check-up within 2 weeks of their procedures. However, there is variation in the advice a woman may receive, depending upon the clinic she attends and on the abortion method utilised. Some clinics recommend a medical check-up 3 weeks after an abortion.

Complications Following Abortion

Complications following abortion are relatively uncommon and are more likely to be of minor, rather than of major significance. For the vast majority, abortion is a low-risk procedure.

At best, statistics are somewhat varied and risks depend upon gestation of the pregnancy, termination method and anaesthetic used, skill of the operator and profile of the woman (parity, age and general health).

The most common complications are:

- Haemorrhage (0.15%)
- Uterine perforation (0.1-0.4%)
- Cervical trauma (1%)
- Failed abortion/ongoing pregnancy (0.2% for surgical, 0.6% for medical)
- Post-operative infection (up to 10%).

There is no proven association between induced abortion and subsequent infertility, pre-term delivery or impaired fertility.

AFTERCARE

In a CPA study conducted among Irish women in 4 UK abortion clinics between October 2003 and January 2004, women were asked about their aftercare plans.

Of the women surveyed, 52.5% intended to have post-abortion medical check-ups. One in 4 (24%) intended to seek contraceptive advice from medical professionals. Fourteen percent (14%) intended to seek post-abortion counselling. A very small number (4%) intended to seek out post-abortion support groups (CPA Research Report 12).

Reports from family planning clinics in Ireland would suggest that, in reality, only approximately 10% of women who accessed crisis pregnancy counselling prior to their abortions return to family planning clinics for routine medical check-ups.

The RCOG UK recommends that all women have medical check-ups within 2 weeks of their abortions. It seems that the majority of women deal with the outcomes of their abortions, whether physical or emotional, by themselves. There will be a proportion who may need reassurances about common symptoms, questions answered, medical complications addressed or support with emotional issues. Depending upon her circumstances and/or concerns, a woman may present to you many years after her abortion.

Of those women who DO NOT access post-abortion services, the factors may include:

- No perceived need for a medical check-up, contraceptive advice or counselling
- No pre-travel medical assessment and/or counselling
- Lack of awareness of willing agencies/ individuals who provide care
- Poor experience in dealing with an unsympathetic healthcare provider
- Difficulty in acknowledging the pregnancy
- Secrecy of pregnancy/abortion
- Fear surrounding confidentiality issues
- Problems pertaining to accessibility of services, e.g. perceived costs, travelling long distances, lack of childcare or difficulty getting time off work.

Of those women who DO access services, the factors cited include:

- Medical necessity (routine or urgent post-abortion care)
- Need for contraception
- Experience of kindness and sympathy from a GP or counsellor before travelling for the abortion.

Irish women may present to a variety of individuals after their abortions:

- GPs
- Other doctors, e.g. gynaecologists, reproductive health specialists
- Nurses
- Crisis pregnancy counsellors
- Social workers
- Maternity hospital staff members
- Private counsellors and therapists.

A woman who has had an abortion may present to you for support, services or information including:

- A medical check-up within a few weeks after the procedure
- Contraceptive advice (only)
- Counselling and support.

A woman may also present to you with symptoms that she considers linked to the procedure:

Relatively soon after the procedure:

- With a physical problem that warrants urgent attention, e.g. pain, fever, excessive bleeding
- With a non-physical issue such as sleeping problems, emotional concerns
- With questions or the need for reassurance regarding comparatively minor and common symptoms
- With the need for help with administrative items, e.g. request for sick note for time off work.

OR

Some time after the procedure:

- With emotional issues pertaining to her abortion, e.g. poor adjustment, regret, anger or concerns over future fertility.

It is important to note that:

- Practically all Irish GPs offer post-abortion care (over 95% of GPs surveyed in 2004). This number has increased from the 88% cited in research undertaken in 1998 (*Women's Health Services in General Practice, ICGP 2006*).
- Family planning clinics in Ireland offer a comprehensive range of services including medical check-ups, contraceptive advice and counselling. A woman may avail of these services at any time, and need not have consulted with the family planning clinic prior to her abortion.
- There are many organisations offering counselling and support services, free of charge, to a woman after an abortion. These services are funded by the CPA, and are also available to a woman's partner or family members.

See contact details in Section 2.

SUPPORTING YOUR PATIENT – MEDICAL CHECK-UP

The purpose of the post-abortion medical check-up is to:

- Establish both the physical and psychological well-being of the woman
- Establish that the pregnancy was terminated, and that the woman has no retained products of conception or indications of infection
- Address the subject of prevention of further unwanted pregnancies through the use of appropriate contraception.

The medical check-up also presents an opportunity for a woman and her doctor to discuss any concerns or issues. In all circumstances, it is important that the woman be received in a non-judgemental manner, be supported and encouraged to talk about her experience, and have her queries addressed, as necessary.

For most women, it is not necessary to have an internal examination performed. An internal examination is only required in instances of specific symptoms which need to be investigated.

CHECK-LIST

- Ascertain physical symptoms within 'normal' range
- Address any queries
- Carry out pregnancy test, if indicated
- Follow up on Chlamydia/other STI screening
- Discuss contraception
- Give contact details in case of further needs in future.

KEY ISSUES IN AFTERCARE

COMMON PHYSICAL SYMPTOMS AND SIGNS

Pain – Like a menstrual cramp, but may be more intense. Treatment with over-the-counter pain remedies will provide adequate pain relief for most women.

Bleeding – Usually vaginal bleeding, with or without clots, lasts for up to 14 days (and even longer after a medical abortion). Initially, it will be bright red in colour and reduce to brown staining within 2 weeks. It is normal to have intermittent spotting until the next menstrual period.

Vaginal Discharge – Two (2) weeks after an abortion, any vaginal discharge should be relatively odourless.

Continuing Symptoms of Pregnancy – Such as breast tenderness, nausea, etc. May persist for some days after the abortion, but should dissipate after a week.

Emotions – Short-term emotional distress is common after an abortion. Although a woman may report a feeling of relief, so too may she report feelings of sadness, regret, loneliness and stigma.

URGENT MEDICAL CARE INDICATORS

May indicate complications in early days or weeks after the procedure:

Severe Pain – Severe pelvic, abdominal, chest or shoulder-tip pain.

Excessive or Prolonged Bleeding – Unusually heavy loss, e.g. continuous and heavy bleeding (enough to soak 3 or more pads within one hour or bleeding beyond 14 days), warrants attention.

Foul-Smelling Vaginal Discharge

Fever

Feeling Generally Unwell – Nausea, headache.

Fainting

Persisting Symptoms of Pregnancy – Nausea, breast tenderness, delayed menstruation.

One or more of these symptoms or signs may indicate infection, retained products of conception, persisting or ectopic pregnancy, uterine rupture or another intra-abdominal or pelvic problem.

Any doubt regarding diagnosis warrants referral to gynaecology or emergency services for immediate further care.

Moderate infection may be conservatively treated (i.e. without referral) by a GP or gynaecologist with diagnostic ultrasound, swabs and empiric treatment with antibiotics.

Suggested Regime

1. Ofloxacin 400mg orally BD (twice daily) x 14 days

OR

2. Erythromycin 500mg orally BD (twice daily) x 14 days if intolerant to Ofloxacin

PLUS

Metronidazole 400mg orally BD (twice daily) x 14 days.

COMMON PATIENT QUERIES

Aftercare leaflets cover many commonly asked questions, but a woman may need other queries answered:

Confirmation that the Pregnancy has Ended

This is not strictly necessary in all follow-up appointments, but it is easy to do by using on-the-spot pregnancy testing kits. Although the pregnancy test will remain positive for a few days after the abortion, it should be negative after 2 weeks.

Sexual Intercourse

While there is no restriction on a woman having intercourse after an abortion, she should be encouraged to use condoms for at least 3 weeks after the procedure. This is intended to reduce the risk of infection and pelvic inflammatory disease.

Menstrual Cycle

The next menstrual period can occur at any time from 3 to 9 weeks after an abortion. Ninety percent (90%) of women will ovulate within 4 weeks of a 1st trimester abortion. Consequently, the need for reliable contraception is important.

Future Fertility

Provided the termination procedure had no complications, there is no convincing evidence to suggest that abortion has a negative effect on a woman's future fertility or her ability to have children.

Breast Cancer

Research evidence shows that having an abortion does not increase the risk of developing breast cancer.

Contraception

For most methods of contraception, a woman may start immediately after her abortion. See this resource's 'CONTRACEPTION' sub-section and contraceptive methods table for more details.

PREGNANCY TESTING

A pregnancy test is not always necessary. In the clinic discharge letter, it may be specifically advised to have this test at about 3 weeks, post-abortion, particularly if the abortion occurred at early gestation. However, it is also an opportunity to provide the woman with the reassurance that she is no longer pregnant.

SEXUALLY TRANSMITTED INFECTION (STI) SCREENING

British abortion clinics vary with regard to their policies surrounding screening for STIs and lower genital tract organisms at the time of abortion. Some clinics routinely test, while others simply offer the tests to their patients.

In practice, many Irish women at British abortion clinics do not opt to have testing performed, as there is an additional cost (approximately €40) which may not have been considered before travelling. If screening is done, it is necessary for Irish women to provide their contact details in the event that any results are positive.

If a woman was tested for STIs at the time of her abortion, she may already have been contacted by the local genito urinary medicine (GUM) clinic affiliated with the clinic in which she had her abortion. Contact is usually made only if test results are positive.

Most clinics provide antibiotics after an abortion. If antibiotics were taken (including those specifically intended for Chlamydia), enquire to check that your client finished her course of tablets. A test-of-cure is not necessary if she has been fully compliant in this regard. If compliance is uncertain or your patient is particularly concerned, a test-of-cure (usually urinary PCR for Chlamydia trachomatis) is best done 4 weeks after

completion of the course of antibiotics.

If the test result was positive and antibiotics were not given (or taken by the woman), she will now need treatment with:

Doxycycline 100mg (BD (twice daily) orally for one week)

OR

Azithromycin 1g (stat orally (greater compliance)).

For Irish women, there is no clear protocol for contact tracing once they return to Ireland. In the case of positive STI test results, it is advisable to attempt contact tracing of the woman's recent sexual partner(s). This is in an effort to reduce rates of re-infection and potential infection transmission.

Contact tracing can be difficult, owing to limitations such as: absence of resources and information, confidentiality stipulations, and non-compliance with prescribed regimes.

Through discussion, it may become evident that there is a need for further or more comprehensive STI testing. Many GPs (54%) provide STI testing in primary care or will opt to refer patients to other services (Women's Health Services in General Practice, ICGP 2006). The medical check-up presents a good opportunity to educate your patient on the ways of avoiding future STIs.

CONTRACEPTION

On the days of their abortions, all women are counselled regarding future contraception. Initiation of contraceptive methods at this time is advantageous, in that a woman is known not to be pregnant and her motivation to accept contraception is high. If she has commenced a particular method at the time of her abortion, the medical check-up is an opportunity to enquire about how it is suiting her so far. All GPs provide contraceptive advice.

Aftercare leaflets advise abstinence or using condoms during intercourse for at least 3 weeks after the abortion. This is intended to reduce the risk of infection and pelvic inflammatory disease.

See this resource's 'CONTRACEPTION' sub-section and contraceptive methods table for more details.

EMOTIONAL AND PSYCHOLOGICAL ISSUES

The experience of abortion is different for everybody. Differences depend upon many variables, and the effects cannot be categorised or predicted. Data and research on the psychological effects of abortion is extremely varied and, at best, must be considered inconsistent. The vast majority of women having abortions will experience a range of emotions as normal reactions afterwards. The routine post-abortion medical check-up presents an opportunity for a woman to address her questions and

concerns to a sympathetic listener, and to voice any feelings about her experience. The practitioner should provide a non-judgemental approach and adequate time for the woman to talk, and then determine whether further counselling is desirable or perceived as necessary, either by the woman or the practitioner.

Commonly reported feelings and emotions include:

- Relief, often immense
- Guilt, sadness, loss, regret over actions
- Anger directed towards self or others (the father, family/friends, society, God)
- Fear of the future, particularly the return of any of these or other feelings.

Only a small minority of women experience any long-term psychologically adverse effects after an abortion. Certain groups of women have been identified as being at increased risk of psychological morbidity, according to the RCOG UK:

- Those who are ambivalent before the procedure
- Those without supportive partners
- Those with previous psychiatric histories
- Members of cultural groups that consider abortion wrong
- Those who have medical indications for terminating their pregnancies.

In a very small proportion of women, there may be a need to consider psychiatric treatment, for example, commencement of medication or referral for assessment by a psychiatrist.

Many women do not experience any psychologically adverse effects after abortion, and may feel that they have made the right decision for them at that time. However, some women may feel distressed shortly afterwards or later on. If the woman has kept her abortion a secret from many or all of her family and friends, in particular, her partner/the father, this may increase the distress. If your patient or client is demonstrating signs of distress or depression after an abortion, she may benefit from one-to-one post-abortion counselling or by joining a support group.

Such support may be accessed through:

- Crisis pregnancy counselling services
- GPs
- Family planning clinics
- Private counsellors and therapists.

Many of these services are free of charge, and women should be encouraged to choose the services that they think would suit them best.

See Section 2 for contact details.

SPECIFIC ISSUES

Settings for Care

The closest gynaecology service for your patient may be in the local maternity hospital. Visiting such a setting for urgent medical care may cause or exacerbate any emotional trauma that your patient may feel about having had an abortion, particularly if she is faced with the obstetric clinic/wards. Sensitivity is called for in these situations and, if possible, all efforts must be made to avoid such settings.

It is advisable to give a letter to the patient (if/when she does present for urgent care), specifying your concerns regarding her health. Thus, recording the fact that she has recently had an abortion is unavoidable. It is best to discuss this with the woman before she goes to the hospital, so that she is aware that the gynaecologist/emergency care doctor/nursing staff members will be informed.

Vulnerable Individuals

After the abortion, it may come to light that the procedure was undertaken to terminate a pregnancy of dramatically adverse circumstances, e.g. rape or incest. The client may not have reported the event(s) to anyone until after her abortion and, in these circumstances, additional sensitivity is required. It is imperative to offer your client support and appropriate onward referral, if requested. She may decide to disclose her circumstances to

you, and she may also wish to make a report to An Garda Síochána, a social worker or rape crisis centre staff members.

Counselling Women from Different Societal Groups

You may come into contact with women with specific needs, e.g. women with literacy issues or migrant women. Apart from obvious barriers such as language, these women may have differing needs to those of the general population, owing to cultural backgrounds or religious beliefs. In supporting these clients, you should endeavour to be sensitive towards their beliefs and requirements.

Late Presentation

Women may present months, years or decades after having had abortions. There may be psychological issues themed with regret, denial of the pregnancies or the abortions, or anger directed at themselves or others. It is important for women to have people to support and help them in these cases.

CONTRACEPTION

The fact that abortion occurs highlights the general failure of contraception.

'Failure' in this context can be given to mean either non-use of any method, or inappropriate or incorrect use of a contraceptive method. UK statistical data shows that 32% of women undergoing abortions in the UK in 2005 had one or more previous abortions (UK NSO 2005). This indicates an important need for contraceptive advice and intervention after an abortion.

In 2004, CPA research findings indicated that 62% of women who had experienced a crisis pregnancy stated that no contraceptive methods were used at the time. Of those who did use contraception, 31% did not know why it failed. Thirty-five percent (35%) of female respondents could not correctly identify when they were most likely to become pregnant within their menstrual cycles (ICCP CPA Research Report 7).

This research suggests a broad level of misconception and lack of knowledge around fertility, contraceptive methods and their use. Women are more likely to change their contraceptive methods at specific times in life, including after accidental pregnancies. The time period after a woman's abortion provides an invaluable opportunity to counsel and educate her about her contraceptive practices (if any) and, through discussion, establish her need for future contraception, which will be safe, reliable and, above all, effective. In choosing a contraceptive method, consideration should be given to the woman's profile and

medical eligibility for the method. Most methods of hormonal contraception are best commenced on the day of the procedure. If a woman presents to her GP some time after the abortion, then she can be advised to start the Pill on the first day of her next period, and should be encouraged to use condoms in the meantime.

Although intrauterine devices like the IUCD (coil) and IUS (Mirena) may be fitted directly after the abortion, this presents a logistical difficulty for most Irish women, as it needs to be arranged prior to their procedures. This usually happens in a consultation prior to the abortion itself. A woman who wishes to use this method of contraception can have an intrauterine device fitted during her next period, and should be encouraged to use condoms in the meantime.

Sterilisation can be performed safely at the time of the abortion. When this procedure is combined with an abortion, it is associated with higher rates of failure and of regret by the woman. It is unlikely to be an option in many of the private clinics where Irish women have abortions. See Contraceptive Methods Table for more detail.

Emergency Contraception

If unprotected sexual intercourse has occurred since the abortion (i.e. no method of contraception was used), then

emergency contraception should be considered as:

Levonorgestrel 1500mcg (orally within 72 hours of intercourse; the sooner it is taken, the more effective it is)

OR

An emergency IUCD (coil) within 5 days of unprotected intercourse.

If an IUCD is inserted as emergency contraception after an abortion, it is recommended that (at minimum) oral antibiotics are provided as infection prophylaxis.

Contraceptive Method	When to Start
Hormonal	
Combined Oral Contraceptive (COC), 'the Pill'	Start immediately following a first trimester abortion. If started 7 days after an abortion, an additional method is required for 7 days.*
Combined Contraceptive Patch (Evra)	Start immediately following an abortion if it occurred at less than 7 days after the last patch, an additional method is required for a further 7 days. If started 7 days after an abortion, start on Day 1. If started after 7 days, start on Day 1. An additional method (e.g. barrier method) is required for 7 days.
Intravaginal Combined Contraceptive Ring (Nuvaring)	Start immediately following a first trimester abortion. If started 5 days after an abortion, start on Day 1. Following a second trimester abortion, start on Day 28.
Progesterone-Only Pill (POP, Mini-Pill)	Start immediately following a first trimester abortion. If started 7 days after an abortion, an additional method is required for 7 days.*
Progestogen-Only Implants	Start immediately following a first trimester abortion. If started 7 days after a second trimester abortion, start between Days 21 and 28. If started after 28 days, start on Day 1.
Progestogen-Only Injectables (Depo-Provera)	Start DMPA (Depot Medroxyprogesterone Acetate) on the day of a first trimester abortion – no additional method is required. If started 7 days after an abortion, an additional method is required for 7 days.*
Levonorgestrel-Releasing Intrauterine System (LNG-IUS, Mirena)	Start immediately following an abortion. If not started on the day of an abortion, then delay insertion until 4 weeks post-abortion.* Higher effectiveness than other hormonal methods.
Non-Hormonal	
Condoms	May be used as soon as intercourse is resumed. A good interim method. Also should be employed if there is a current risk of STI transmission.
Copper Intrauterine Device (IUD)	Insert immediately following a first trimester abortion. Otherwise, fitted at the time of a second trimester abortion.
Spermicides	May be used as soon as intercourse is resumed. Poor protection as a sole method (e.g. diaphragm).
Other Barrier Methods (Diaphragm, Cervical Cap)	A diaphragm may be fitted immediately after a first trimester abortion. A cervical cap may be fitted 2-3 weeks after a second trimester abortion.
Fertility Awareness-Based Methods	These are not recommended for use after an abortion. They may be used after a second trimester abortion. Examples include the rhythm method and the Persona method.
Tubal Ligation	This can be performed immediately after an uncomplicated abortion because of time constraints and consultation/planning with the surgeon. This procedure upon returning home, referral to the appropriate reproductive health method in the intervening period is also necessary.

*Some recommendations for contraceptive use after an abortion fall outside the product licence; the recommendation is based on clinical evidence. Effectiveness is given as % effective against pregnancy in a general setting, not specifically in the post-abortion setting. Where the recommendations state 'first trimester abortion,' the method should be commenced on the day of the abortion.

	Effectiveness
days after an abortion, an additional method (e.g. condoms) is required	99% when used correctly.
20 weeks' gestation. If a delay of up to 7 days occurs in starting the abortion occurred at or more than 20 weeks' gestation, delay use of the recommended for this time and for the first 7 days of use.*	99% when used correctly.
days after an abortion, an additional method is required for 7 days.*	99% when used correctly.
days after an abortion, an additional method is required for 2 days.*	96-99% with careful use.
days after an abortion, an additional method is required for 7 days. Following Day 28, an additional method is required for 7 days.*	99%
surgical abortion or on the day of the second part of a medical abortion, an additional method is required for 7 days.*	99% when administered at recommended intervals.
of a surgical abortion or on the day of the second part of a medical abortion, risk of expulsion if fitted at the time of a second trimester abortion.	99%
method if another method is chosen but cannot be started immediately.	Depends upon the user; 95-98% when used correctly.
, delay insertion until 4 weeks post-abortion. Higher risk of expulsion if	98-99%
against pregnancy unless used in conjunction with another method (e.g.	Poor if used alone.
abortion. The diaphragm and cervical cap should not be used until about 6	Depends upon careful and consistent use; 92-98% when used very carefully.
be used as soon as the woman has completed 3 menstrual cycles after intrauterine device.	80-98%
abortion. In practice, Irish women do not avail of this option while abroad or before the procedure. However, if the woman wishes to avail of resources for consultation is necessary. Use of another contraceptive	Overall failure rate up to 0.5%.

Recommendations made here are evidence-based (FFPRHC).

in a clinical setting.

Use of another contraceptive method after a surgical abortion or on the day of the second part of a medical abortion.

SECTION TWO

DIRECTORY OF AGENCIES AND SUPPORT SERVICES

GPs (GENERAL PRACTITIONERS)

Nearly all Irish GPs (95%) provide medical care to a woman after an abortion.

This encompasses the:

- Physical check-up
- Contraceptive advice
- STI service(s)
- Counselling, if necessary
- Any further follow-up care, if needed.

Attending her own GP provides a woman with an advantage in terms of continuity of care and general awareness of her pre-morbid physical and psychological well-being.

Attending her own GP provides a woman with an advantage in terms of continuity of care and general awareness of her pre-morbid physical and psychological well-being. Attending the GP will incur a cost for the consultation, although this may be waived if she holds a valid medical card. GPs who do not provide one of the aforementioned services will usually refer the woman to another GP or agency.

FREE POST-ABORTION MEDICAL CHECK-UPS AND CONTRACEPTIVE ADVICE

CORK FAMILY PLANNING CLINIC

TEL: 021 427 7906

DUBLIN WELL WOMAN CENTRES

Dublin 1

TEL: 01 872 8051/95

Dublin 4

TEL: 01 660 9860/668 1108

Dublin 5

TEL: 01 848 4511

IRISH FAMILY PLANNING ASSOCIATION (IFPA)

CALLSAVE TEL: 1850 49 50 51

LIMERICK FAMILY PLANNING CLINIC

TEL: 061 312 026

SEXUAL HEALTH CENTRE, CORK

TEL: 021 427 6676/5837

TRALEE FAMILY PLANNING CENTRE

TEL: 066 712 5322

YOUTH HEALTH SERVICE, CORK

TEL: 021 422 0490/1

FREE POST-ABORTION COUNSELLING

BALLINASLOE CRISIS PREGNANCY SUPPORT SERVICE (BALLINASLOE CPS)

CALLSAVE TEL: 1850 20 06 00

CURA

CALLSAVE TEL: 1850 62 26 26

DUBLIN WELL WOMAN CENTRES

Dublin 1

TEL: 01 872 8051/95

Dublin 4

TEL: 01 660 9860/668 1108

Dublin 5

TEL: 01 848 4511

IRISH FAMILY PLANNING ASSOCIATION (IFPA)

CALLSAVE TEL: 1850 49 50 51

LIFE PREGNANCY CARE

CALLSAVE TEL: 1850 28 12 81

MAYO CRISIS PREGNANCY SUPPORT SERVICE (MAYO CPS)

LO CALL TEL: 1890 20 00 22

MIDLANDS CRISIS PREGNANCY COUNSELLING SERVICE (MIDLANDS CPCS)

FREEPHONE: 1800 20 08 57

ONE FAMILY (FORMERLY CHERISH)

LO CALL TEL: 1890 66 22 12

PACT

CALLSAVE TEL: 1850 67 33 33

SEXUAL HEALTH CENTRE, CORK

TEL: 021 427 6676/5837

TRALEE FAMILY PLANNING CENTRE

TEL: 066 712 5322

WEST CORK CRISIS PREGNANCY COUNSELLING SERVICE

LO CALL TEL: 1890 25 23 59

YOUTH HEALTH SERVICE, CORK

TEL: 021 422 0490/1

CRISIS PREGNANCY COUNSELLING

POSITIVE OPTIONS

Positive Options is a directory of agencies skilled in the area of crisis pregnancy counselling. For details, visit www.positiveoptions.ie or (from a mobile telephone) Freetext the word LIST to 50444. Alternatively, contact the Crisis Pregnancy Agency for a printed leaflet.

STI SCREENING

Treatment in an STI or GUM clinic is confidential, free of charge and non-judgemental. Any medication or treatment is also provided, free of charge. Clinic

times and appointment systems may vary; telephone ahead to confirm. Many GPs and family planning centres offer STI screening, however, there may be a charge for this service.

BALLINASLOE INFECTIOUS DISEASE CLINIC

Portiuncula Hospital

Ballinasloe, Co. Galway

TEL: 090 964 8200 EXT: 676

CARLOW STI CLINIC

Carlow District Hospital

Co. Carlow

TEL: 051 842 646

CLONMEL STI CLINIC

South Tipperary Hospital (formerly St. Joseph's)

Clonmel, Co. Tipperary

TEL: 051 842 646

CORK STI CLINIC

Victoria Hospital

Old Blackrock Rd, Cork

TEL: 021 496 6844

ENNIS STI CLINIC

Mid-Western Regional Hospital

Ennis, Co. Clare

TEL: 061 482 382

GALWAY STI CLINIC

University College Hospital, Galway

TEL: 091 525 200

**GENITO URINARY MEDICINE AND
INFECTIOUS DISEASES (GUIDE) CLINIC**

St James' Hospital

James' St, Dublin 8

TEL: 01 416 2315/6

MAIN TEL: 01 410 3000

HIV TESTING

Drugs/HIV Helpline

FREEPHONE: 1800 45 94 59

LIMERICK STI CLINIC

Limerick Regional Hospital

Dooradoyle, Co. Limerick

TEL: 061 482 382

MATER STI CLINIC

Mater Misericordiae Hospital

Eccles St, Dublin 7

TEL: 01 803 2063

MAYO INFECTIOUS DISEASE CLINIC

Mayo General Hospital

Castlebar, Co. Mayo

TEL: 094 902 1733

NENAGH STI CLINIC

Nenagh General Hospital

Co. Tipperary

TEL: 061 482 382

SLIGO STI CLINIC

Sligo General Hospital

Co. Sligo

TEL: 071 917 0473

TRALEE STI CLINIC

Tralee General Hospital

Co. Kerry

TEL: 021 496 6844

WATERFORD STI CLINIC

Waterford Regional Hospital

Co. Waterford

TEL: 051 842 646

**ADDITIONAL
COUNSELLING SUPPORT
SERVICES**

**IRISH ASSOCIATION FOR COUNSELLING
AND PSYCHOTHERAPY (IACP)**

8 Cumberland St, Dun Laoghaire, Co.

Dublin

TEL: 01 230 0061

WEB: www.irish-counselling.ie

**IRISH COUNCIL FOR PSYCHOTHERAPY
(ICP)**

73 Quinns Rd, Shankill, Co. Dublin

TEL: 01 272 2105

SAMARITANS

24 HOUR HELPLINE: 1850 60 90 90

WEB: www.samaritans.org

USEFUL RESOURCES FOR PATIENTS AND CLIENTS

For additional information, to view research reports and to sign up to the e-newsletter, please visit www.crisispregnancy.ie

AFTERCARE: WHEN YOU RETURN HOME

A leaflet listing post-abortion services in Ireland. It also contains information on medical check-ups, contraception, urgent medical care, and the feelings and emotions of your client after an abortion.

CONTRACEPTION 35-55

A leaflet with information on the suitability of different types of contraception as women get older. It encourages women to consider their contraceptive options and provides important health information.

KEY CONTACT: DIRECTORY OF SUPPORTED ACCOMMODATION FOR WOMEN EXPERIENCING CRISIS PREGNANCY

KEY CONTACT: INFORMATION AND SERVICE DIRECTORY ON REPRODUCTIVE AND SEXUAL HEALTH AND PREVENTION OF CRISIS PREGNANCY

KEY CONTACT: PRIMARY CARE GUIDELINES FOR THE PREVENTION AND MANAGEMENT OF CRISIS PREGNANCY

Galimberti, R. and Ni Riain, A. (2004)

Available from the ICGP.

KEY CONTACT: REPRODUCTIVE HEALTH INFORMATION FOR MIGRANT WOMEN

The resource is accompanied by a CD-ROM with information in 6 languages.

It is available from:

Treoir (National Federation of Services for Unmarried Parents and Their Children)

LO CALL TEL: 1890 25 20 84

KEY CONTACT: RESPONDING TO CRISIS PREGNANCY: INFORMATION AND SERVICE DIRECTORY FOR COMMUNITY AND HEALTH PROFESSIONALS

Available for the following areas:

- HSE Dublin North City and County/North Eastern Area
- HSE West
- Former Southern Health Board

POSITIVE OPTIONS

Positive Options is a directory of agencies skilled in the area of crisis pregnancy counselling. For details, visit www.positiveoptions.ie or (from a mobile telephone) Freetext the word LIST to 50444. Alternatively, contact the Crisis Pregnancy Agency for a printed leaflet.

THINK CONTRACEPTION

A leaflet and website with information for men and women who want to learn more about their sexual and reproductive health, especially contraception. It contains a handy reference guide to all available contraception.

WEB: www.thinkcontraception.ie

ICGP RESOURCES IRISH COLLEGE OF GENERAL PRACTITIONERS

WEB: www.icgp.ie

Ni Riain, A. et al (2006)

Women's Health Services in General Practice

O'Carroll, Austin and O'Riordan, Margaret (1996)

Counselling in Practice: A Guide for General Practitioners

USEFUL WEBSITES AND RESOURCES

CITIZENS' INFORMATION CENTRES

WEB: www.citizensinformation.ie

ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS IN THE UK

WEB: www.rcog.org.uk

Medical Eligibility Criteria for Contraceptive Use

3rd Edition (2004)

visit

WORLD HEALTH ORGANISATION

WEB: www.who.int

GLOSSARY

CONTACT TRACING

The practice of identifying the sexual contacts (past and/or present) of an individual diagnosed with a sexually transmitted infection (STI). This practice usually involves an attempt to test and treat the sexual contacts for STIs.

ECTOPIC PREGNANCY

A pregnancy that has developed outside of its normal location, usually in a fallopian tube instead of the uterus.

EMPIRICAL TREATMENT

Treatment (in this context, antibiotics) given because effectiveness has been observed in previous, similar cases.

GESTATION

The time period from conception to birth, generally 9 months.

GESTATIONAL SAC

The membranous bag that surrounds the fetus in the womb.

INTRAUTERINE

Meaning 'within the uterine cavity/uterus or womb.'

LOWER GENITAL TRACT

The part of the female anatomy that includes the external genitals, the vagina and the neck of the womb.

PARITY

Referring to the number of pregnancies a woman has had, usually resulting in live births.

PELVIC INFLAMMATORY DISEASE (PID)

Inflammation of the inner reproductive organs of a woman which can lead to infertility.

PREMORBID

A term given to indicate a person's medical or psychological state before an event.

PRE-TERM DELIVERY

The birth of a baby before 37 weeks' gestation.

RHESUS PROPHYLAXIS

An injection of a blood derivative to help stop a woman from forming antibodies against foetal blood cells.

SEQUELÆ

Complications following a disease, disorder or injury.

STI

Sexually transmitted infection.

TEST-OF-CURE

A medical test, usually involving a swab or urine sample, to verify that treatment for an infection or condition has been successful.

TRIMESTER

A 3 month period of time. Pregnancy is divided into 3 trimesters: first trimester (up to around 13 weeks); second trimester (between 13 and 26 weeks); third trimester (between 27 and 40 weeks).