Abortion care: anti-D prophylaxis update

Draft for consultation, March 2025

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

This guideline will update NICE guideline NG140 (published September 2019).

Who is it for?

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

What does it include?

- new and updated recommendations on anti-D prophylaxis
- the rationale and impact section that explains why we made the 2025 recommendations and how they might affect services.

Information about how the guideline was developed is on the guideline's webpage. This includes the supporting document for why the recommendations were made.

New and updated recommendations

We have updated the recommendations on anti-D prophylaxis for people having an abortion. You are invited to comment on the new and updated recommendations. These are marked as **[2019, amended 2025]** or **[2025]**.

The advice on the use of anti-D prophylaxis was updated to refer to existing World Health Organization guidance. See the rationale and impact section on anti-D prophylaxis and the supporting document for more details.

1 Recommendations

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

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

Abortion Act 1967

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

In May 2014, the Department of Health and Social Care issued guidance in relation to requirements of the Abortion Act 1967. This guidance is intended for those responsible for commissioning, providing and managing the provision of abortion services to help them comply with the Abortion Act. Also in May 2014, the Department of Health and Social Care published procedures for the approval of independent sector places for the

termination of pregnancy. Further government guidance has recently been issued in the form of letters from the Chief Medical Officer.

Providers of abortion services must comply with the Health and Social Care Act 2008 and regulations made under that Act. In particular, providers must register with the Care Quality Commission (CQC). This is because under section 10 of the Health and Social Care Act 2008, it is an offence to carry out a regulated activity without being registered with the CQC, and abortion is a 'regulated activity' under Regulation 3 and Schedule 1 (paragraph 11) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (SI 2014/2936). The CQC imposes specific requirements on providers that are not English NHS bodies (see regulation 20 of the Care Quality Commission (Registration) Regulations 2009).

Additional relevant guidance:

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

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

Consent and Montgomery

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

Gender

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

1.3 Anti-D prophylaxis

1.3.1 For advice on the use of anti-D prophylaxis for people who are rhesus D negative and are having a medical or surgical abortion, follow section 3.3.3 of the World Health Organization Abortion care guidelines. **[2025]**

1.3.2 Providers should ensure that for people who are rhesus D negative and are having an abortion at 12 weeks or over:

- rhesus status testing and anti-D prophylaxis supply does not cause any delays to women having an abortion
- anti-D prophylaxis is available at the time of the abortion. **[2019, amended 2025]**

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

Full details of the evidence are in the supporting document for the recommendations on anti-D prophylaxis.

Terms used in this guideline

Fetal anomaly

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

Feticide

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

Rationale and impact

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

Anti-D prophylaxis

Recommendations 1.3.1 and 1.3.2

Existing World Health Organization (WHO) guidelines on the use of anti-D prophylaxis for people who are rhesus D negative and are having a medical or surgical abortion were cross- referred to, as these reflect current practice. The quality of these guidelines was assessed using the AGREE II tool. These guidelines were assessed as high quality, and therefore the recommendation from this guideline was considered appropriate to cross-refer to. Further rationale and information about this recommendation can be found in the rationale for the WHO recommendation and the supporting evidence review.

The WHO recommendation is also in line with the Royal College of Obstetricians and Gynaecologists best practice in abortion care paper which states that 'If available, anti-D should be offered to non-sensitised RhD-negative individuals from 12 weeks of pregnancy and provided within 72 hours of the abortion.' Therefore an existing recommendation was amended to ensure that people who need anti-D prophylaxis

when having an abortion at 12 weeks or over do not incur delays in receiving treatment because of their rhesus status testing or the availability of anti-D prophylaxis.

How the recommendations might affect practice

This recommendation is in line with current practice and in line with advice set out in the RCOG Best Practice in abortion care.

The supporting document for the recommendations on anti-D prophylaxis includes details of the AGREE assessment of the WHO guideline and considerations leading to this recommendation.

Return to recommendations

Context

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

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

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

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

simplified. Some of these developments could significantly reduce costs to the NHS and be more acceptable to women.

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

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

Finding more information and committee details

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

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

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

Update information

March 2025: The advice on the use of anti-D prophylaxis was updated to refer to existing World Health Organization guidance, as these reflect current practice. See the rationale and impact section on anti-D prophylaxis for more information.

Minor changes since publication

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

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

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

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