Safeguarding and telemedical abortion services

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CHANGES TO ABORTION SERVICES AND THE LAW SURROUNDING PROVISION AS A RESULT OF COVID-19

On 21 March 2020, in response to the coronavirus COVID-19 outbreak, the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of Midwives (RCM), the Faculty of Sexual and Reproductive Healthcare (FSRH) and the British Society of Abortion Care Providers (BSACP) produced clinical guidance for the provision of abortion care. These guidelines were introduced in order to reduce the risk of transmission of COVID-19 to abortion providers and women seeking abortion while allowing service provision through lockdown.[1] As a result, telemedicine was introduced as recommended by NICE guidelines on abortion care.[2] Telemedicine utilises information and communication technology to deliver healthcare services at a distance to increase a client's access to healthcare. This allows healthcare professionals to deliver a service via telephone, video call and the internet. Since the introduction of the COVID-19 restrictions, 85% of abortion consultations are undertaken via telephone or video call in England.[3] These conversations need to be conducted remotely in as safe a manner as possible, and additionally there needs to be the flexibility to provide a face-to-face appointment for those clients who may have difficulty accessing telemedicine or who do not have a private space in which to access a telephone or video call.

During March 2020, the law changed to allow women to undergo an early medical abortion (EMA) in their own home. This change allowed abortion services to post mifepristone and misoprostol (the medications used for EMA) directly to a client (figure 1). Prior to this change, legally mifepristone had to be administered in a licensed premises, such as an abortion clinic or National Health Service (NHS) hospital. However, this is only a temporary measure and is currently time limited to 2 years, or until the pandemic is over, whichever is earliest.[4]

> **Key messages**
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> - Safeguarding must remain a core priority throughout the pandemic, particularly as there is evidence suggesting an increase in reported safeguarding cases during COVID-19, in particular with regard to domestic violence.
> - It has been shown that safeguarding assessments can be carried out effectively during remote consultations with clients being asked to ensure they are alone.
> - Multi-agency collaboration remains a priority when supporting vulnerable clients, especially when the client may not have been seen in person.

RESPONDING TO CHANGES WHILE MAINTAINING SAFEGUARDING DUTIES

The provider should undertake the same assessment regarding routine enquiry questions in relation to patient safety and vulnerability as they would for an in-person visit. This will allow the provider to assess additional needs including post-treatment follow-up or referrals to external agencies such as social services.[5]

During the consultation call, it is important that the provider asks the client if they are alone and if they feel safe at home. If a client reports social services involvement, domestic violence, not feeling safe or is under 18 years of age, the clinician will ask further open-ended probing questions regarding their situation (figure 2). The clinician will ask the client if they are alone in order to complete the assessment and to ensure that the client is in a safe environment that allows for any disclosures. All clients aged under 18 years will be asked to

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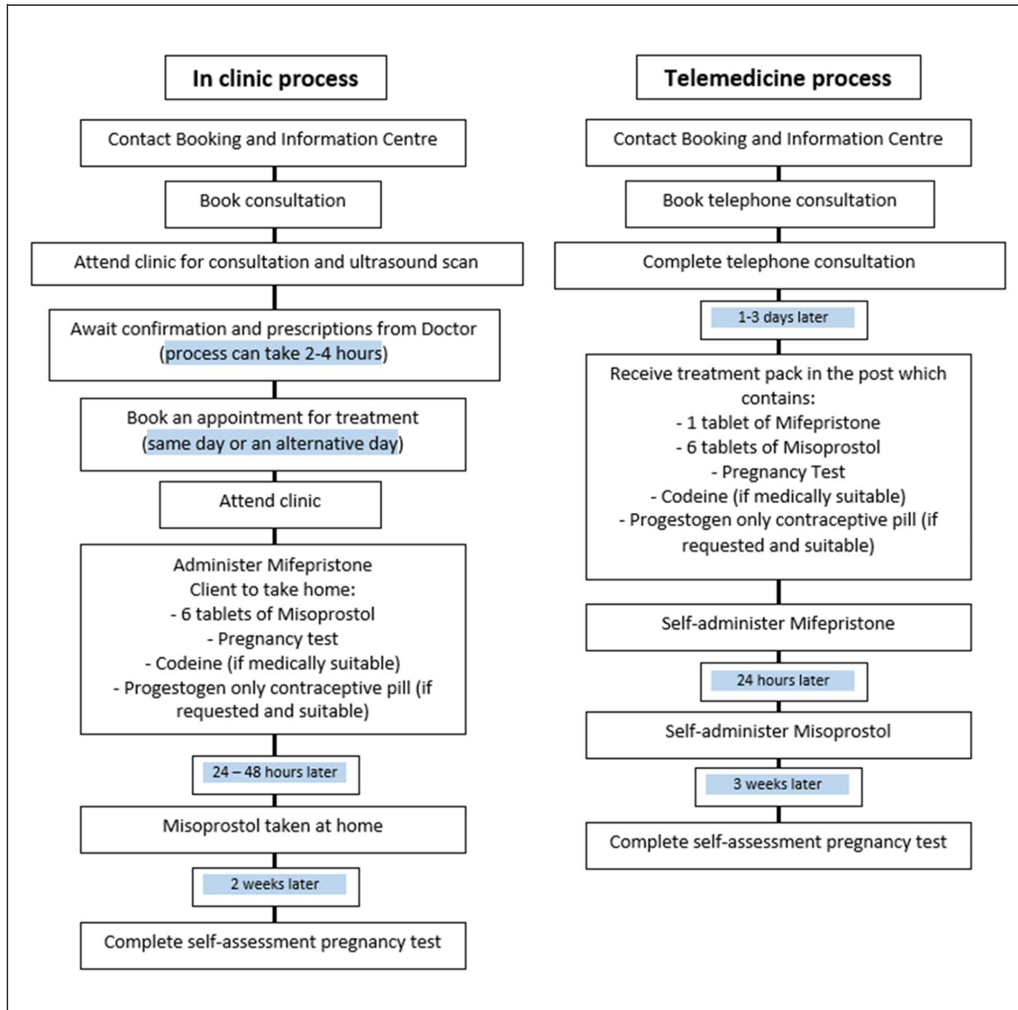

Figure 1 Changes in telemedicine process.

complete the assessment via video call, allowing the clinician to visually assess the client's surroundings for the presence of other people. If there are any concerns about the client not being alone, or if the clinician or client have any concerns, the client is asked to attend a local clinic where a face-to-face assessment can be conducted in private.

SO HOW DOES THIS WORK IN PRACTICE?

Samantha is a 22-year-old woman who is having a remote consultation for a termination of pregnancy. After a discussion around her last menstrual period and medical assessment she is deemed suitable for an EMA. At the start of the telephone call Samantha is asked to confirm if she is in a safe place and is alone and cannot be overheard. When Samantha is asked if she feels safe at home, she responds that she is safe, but her partner has recently been verbally abusive due to losing his job. A Safeguarding Risk Assessment is completed by the clinician (figure 2). Samantha is informed that all information shared is confidential unless the nurse feels that Samantha or anyone else is at risk, in which case the provider would consider sharing the information with other relevant agencies, such as social services or the police domestic violence team. Samantha agrees and discloses that she is worried her partner's behaviour would get worse if he knew about the termination of pregnancy. There are no other concerns disclosed – this is Samantha's first pregnancy, and she has no history of mental health concerns and does not consume alcohol or illegal substances. It is important to consider any children in the household, as a concern with an existing child could be a reason to breach confidentiality or inform social services if this pregnancy continues. Samantha agrees for her general practitioner (GP) to be informed in order to provide ongoing support; contact details for local support services are also offered. In some scenarios it may be appropriate to refer the client to local vulnerable adult teams if ongoing support is required and they do not have a GP or do not wish their GP to be informed about their treatment. Samantha is suitable for the EMA drugs and therefore the medication, together with detailed instructions on how and when to take the medication, will be delivered to her address in discrete packaging via the postal service and the procedure can

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be completed in the comfort of her home at a time convenient to her. A supply of oral contraceptive pills can also be posted in the same pack to provide temporary effective contraception until Samantha can access her preferred method of contraception. Samantha is able to discretely end her pregnancy without arousing suspicion from her partner. Due to the safeguarding concerns regarding the impact that the partner's behaviour may have on Samantha, the clinician arranges to contact Samantha 3 weeks following treatment. During this follow-up call, Samantha confirms that the EMA medication has been taken, that she has produced a negative pregnancy test, and that she feels safe and well. Additionally, her GP has made contact and she has support from a domestic violence charity which is helping improve her relationship with her partner. Samantha reports that she felt safe and comfortable in her own environment during the telemedicine consultation, which allowed her to discuss any concerns and support was able to be provided.

DISCUSSION

The pandemic has had a significant effect on those at risk. For example, a recent survey conducted by Women's Aid (September 2020) found that 61.3% of women experiencing domestic violence felt that the abuse has increased during the pandemic.[6] Some 76.1% of women reported spending more time with their

- Do you feel safe at home?
- Is it your choice to have an abortion?
- Do you require further counselling?
- Who do you live with?
- How are things at home?
- Do you have any children? Do they live at home with you? Are they currently involved with any agencies (such as social services/police/mental health team)?
- Are you currently involved with any other agencies or professionals such as social workers or mental health services? Can we contact them?
- Who knows you are pregnant?
- Do you have friends or family who you can talk to?
- Do you feel safe with the person you had sex with to make you pregnant?
- Have you ever been made to feel scared or uncomfortable by the person(s) you have been having sex with?
- Have you ever been made to do something sexual that you did not want to do, or been intimidated?
- Do you feel you could say no to sex?
- Has anyone given you something like gifts, money, drugs, or alcohol for sex?
- Do you ever use drugs and/or alcohol?
- Do you suffer from feeling down/depression?
- Have you ever tried to hurt yourself or self-harm?
- Have you been cut/circumcised/closed? Have you ever had any operations or been cut on your vagina/genitals/down below? Has anything ever been done to you to change your appearance "down below"? (use terminology appropriate to the client)
- Is your General Practitioner aware of any issues raised? Do you consent to us informing your General Practitioner?

Additional questions for clients under 18 years

- Do you attend school/college? Where do you attend? Do you attend regularly?
- Does anyone at home know you are having sex? If yes, who?
- How are things at home? (Consider if this child is known to the care system, homeless or a runaway)
- Do your friends know and like the person you are having sex with?
- Who did you have sex with to make you pregnant? (Ask for name, age, and occupation/student status). Are you in a relationship with them? How long have you known them? Where did you meet?
- Where did you/do you have sex?
- What age were you when you first had sex? How many sexual partners have you ever had? How many sexual partners have you had in the last 12 months? How old were they?

Figure 2 List of safeguarding risk assessment questions.

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abuser and 78.3% felt that the pandemic had made it harder for them to escape abuse.[7] This can make accessing services, such as abortion services, extremely difficult as women were previously required by law to attend a licensed premises to commence an EMA termination of pregnancy. Therefore, telemedicine has had a positive impact on these vulnerable clients as access to services is much easier and can be arranged at a time convenient to the individual. The British Pregnancy Advisory Service (BPAS), an abortion provider that utilises telemedicine, suggests that telemedicine is not a barrier to identifying safeguarding concerns as the feedback received suggests women find it easier to disclose concerns via telephone in their own homes (or location convenient to them) as opposed to in a clinical environment.[7]

The Working Together to Safeguard Children guide (2018) highlights the importance of a co-ordinated approach whereby practitioners are aware of their own individual responsibilities as well as working in partnership with other professionals and agencies to adequately respond to the needs of children and families. It is now more important than ever, as COVID-19 continues to restrict independence though successive lockdowns, that abortion services respond to women's needs. Women should be able to access abortion care in a way that remains confidential and does not endanger their health by encouraging unnecessary travel during periods of lockdown, and that allows professionals to explore and report any disclosures of abuse. Any concerns are escalated to other agencies such as social services and GPs as appropriate to allow a collaborative approach to ensure that women's safety is paramount.

Some agencies have introduced a 'safe word' alert. This is a specific word given to the client such as 'handbag' or 'ask for Ani', the use of which alerts the clinician to the fact that the client feels unsafe during the consultation and they can then make arrangements for the client to attend a face-to-face appointment.

CONCLUSIONS

Abortion services continue to improve services for women, and they have quickly adapted to continue to provide safe and effective care during a global pandemic. This change has allowed women to access abortion care from the safety of their own homes and complete their treatment at a time convenient to them, thus promoting independence and autonomy around their own health and reproductive rights.

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