

## 'EXCELLENCE IN ADVERSITY: ABORTION CARE IN THE CORONAVIRUS PANDEMIC'

Online Webinar Conference Jointly Organised by the British Society of Abortion Care Providers and the Royal Society of Medicine's Sexuality & Sexual Health Section held on 12 October 2020

This was the fifth annual conference organised by the British Society of Abortion Care Providers (BSACP), a multi-professional society formed in 2014 to promote best practice, education, training and research in abortion care in the United Kingdom of Great Britain and Northern Ireland, its Crown Dependencies and Other Territories. BSACP serves its members by providing a forum for professional development and networking, as well as by raising the profile of the specialty and improving understanding amongst those responsible for abortion-related policy, guidance, commissioning, regulation and training. Further information about the Society, including how to become a member and support BSACP's aims, is available at <https://bsacp.org.uk>.

'Excellence in Adversity: Abortion Care in the Coronavirus Pandemic' was the first online national conference aimed at enabling UK abortion providers to come together to learn about, discuss and debate the impact of the pandemic and other key issues relevant to abortion care and provision.

The conference comprised presentations by invited speakers and interactive workshops. The abstracts that follow are from those authors competitively selected to deliver a short presentation of their work during the free communication sessions at the conference. The live presentations were chosen from a large number of good quality abstract submissions.

### 1 QUALITY IN ABORTION CARE: PERSPECTIVES OF SERVICE USERS

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**Introduction** There is little agreement of what constitutes quality in abortion care or the recommended indicators for its measurement, particularly from the service users' perspective.

**Methods** We conducted one-to-one interviews, by phone or in person, with individuals who had an abortion in the previous 6 months at one of seven geographically dispersed British Pregnancy Advisory Service (BPAS) clinics in England and Wales. The topic guide explored:

- Experiences of quality in abortion care
- Perceptions, definitions, and most important elements of quality
- The relationship between abortion stigma and quality.

Interviews were audio-recorded, transcribed, and analysed for common themes. The study was approved by the National Research Ethics Service and BPAS Research and Ethics Committee.

**Results** During the period December 2018–July 2019 we conducted 24 interviews. Participants had an average age of 29 years (range 19–42 years). Ten had a surgical abortion and 14

had a medical abortion. Seventeen (71%) were treated in the first 12 weeks of pregnancy and 7 (29%) beyond 12 weeks' gestation. Average gestational age at treatment was 10 weeks +5 days (range 5 weeks–23 weeks+6 days).

Interpersonal interactions with staff were an important contributor to perceptions of quality for nearly all participants. Positive interactions were consistently cited as the best part of participants' abortion experience and negative interactions as the worst. Four aspects of medical services provided emerged as central to quality care: information and preparation for care, providing choices (e.g. location of treatment, method of abortion), measures to protect confidentiality, facilities, and perceptions of staff competency. Accessibility of services also emerged as a key aspect of quality care, specifically in relation to waiting times, travel, and remote consultation.

**Conclusions** Service users centred quality in abortion care on three domains: interpersonal aspects of care, medical services provided, and accessibility. Indicators identified can be used to develop standard metrics to ensure care meets service users' needs.

### REFERENCES

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### 2 UTILITY OF A ROUTINE ULTRASOUND FOR DETECTION OF ECTOPIC PREGNANCIES AMONGST WOMEN REQUESTING ABORTION: A RETROSPECTIVE REVIEW

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**Background** Routine ultrasound may be used in abortion services to determine gestational age and confirm an intrauterine pregnancy. However, women may present before there is definitive evidence of an intrauterine pregnancy and the utility of routine ultrasound in excluding ectopic pregnancy is unclear. We sought to determine the rate of ectopic pregnancy and the utility of routine ultrasound in their detection, in a community abortion service.

**Methods** Retrospective case record review of women requesting abortion over 5 years (2015–2019) at a service conducting routine ultrasound (Edinburgh, UK), with an outcome of ectopic pregnancy or pregnancy of unknown location (PUL). Records were searched for symptoms at presentation, development of symptoms during clinical care, significant risk factors and routine ultrasound findings.

**Results** 29 out of 11 381 women (0.25%, 95% CI 0.18%–0.33%) had an outcome of ectopic pregnancy or PUL (tubal=18, caesarean scar=1, heterotopic=1, PUL=9). 11 (38%) cases had either symptoms at presentation (n=8) and/or significant risk factors for ectopic (n=4). A further 12 women developed symptoms during their clinical care. Of the

remaining 6, 3 were PUL treated with methotrexate and 3 were ectopic (salpingectomy=2, methotrexate=1). However, in 2 of these 6 cases, ultrasound falsely indicated an intrauterine pregnancy.

**Conclusions** Ectopic pregnancies are uncommon amongst women presenting for abortion. The value of routine ultrasound in excluding ectopic pregnancy in symptom-free women without significant risk factors is questionable as it may aid detection of some cases but may give false reassurance that a pregnancy is intrauterine.

### 3 ACCEPTABILITY OF EARLY MEDICAL ABORTION DELIVERED BY TELEMEDICINE – PRELIMINARY DATA FROM AN NHS COMMUNITY ABORTION SERVICE

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**Introduction** In response to the COVID-19 outbreak, the NHS Lothian abortion service (based at the Chalmers Centre for Sexual and Reproductive Health, Edinburgh) transferred wholly to telemedicine delivery of abortion care. The need for ultrasound scan was assessed as per Royal College of Obstetricians and Gynaecologists (RCOG) guidance based on symptoms and/or significant risk factors for ectopic, uncertain gestation or last menstrual period (LMP) of more than 12 weeks ago. Those with a gestation of less than 12 weeks, and medically eligible could choose early medical abortion (EMA) at home with collection of medication or delivery by courier. We sought to evaluate the experience of these women.

**Methods** Between 1 April and 9 July 2020, an interviewer-administered survey was conducted of women who had received EMA, at 4 days and 14 days following their telemedicine consultation. Questions included preparedness for the EMA, acceptability of telemedicine and preferred future type of consultation, importance of ultrasound and result of the day 14 low-sensitivity pregnancy test (LSPT).

**Results** Our preliminary analysis includes 322 women with complete follow up at day 4 and day 14. 281 (87%) of women rated their telephone abortion care as 'very acceptable' or 'somewhat acceptable', and 275 (85%) rated themselves as 'very prepared' or 'somewhat prepared for the procedure'. 236 (73%) had a negative LSPT at day 14. Of the remaining women, less than 1% had an ongoing pregnancy after further investigation. 231 (72%) of respondents would select a telephone consultation again if they needed a further abortion. Only 70 (22%) women considered ultrasound as being 'very important' or 'somewhat important' to them.

**Conclusions** The move to telemedicine has been positively received by the majority of women in our cohort. Continuing to provide the majority of EMA care via telemedicine would appear to be an effective approach, appreciated by patients.

### 4 DO MEDICATION ABORTION COMPLICATIONS INCREASE WHEN MIFEPRISTONE IS AVAILABLE WITHOUT REGULATIONS RESTRICTING PRACTICE? A POPULATION-BASED STUDY USING LINKED HEALTH ADMINISTRATIVE DATA FROM CANADA

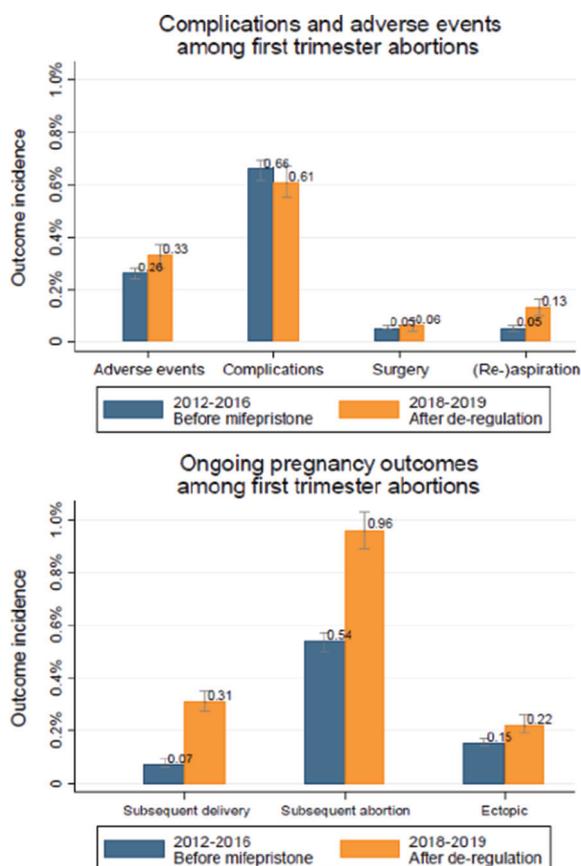
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**Objective** In January 2017, mifepristone became available in Canada, where abortion has been fully decriminalised since 1988. By November 2017, all drug label restrictions on prescribing and dispensing were removed. Canada's globally unique policies allow any physician or nurse-practitioner to prescribe mifepristone physically or via telemedicine, any pharmacist to directly dispense mifepristone to patients, and patients to swallow their mifepristone when and where they choose. In this study, we examined the association of this deregulated medication abortion approach with abortion utilisation and complications including ongoing pregnancy.

**Methods** We used linked administrative data (billing, hospital, ambulatory care, and prescription records) from Ontario, Canada to examine the 308 344 surgical and medication abortions from January 2012 to December 2019. We examined abortion utilisation, abortion after 14 weeks' gestation, abortion-related complications (infection, haemorrhage, embolism, shock, renal failure, damage to pelvic organs, other venous complications) and severe adverse events (overnight hospitalisation, blood transfusion, or death), surgical follow-up (laparotomy, laparoscopy, hysterectomy), aspiration/re-aspiration, and ongoing pregnancy (ectopic, intrauterine) within 6 weeks of the abortion. We compared incidences before and after mifepristone deregulation (2012–2016 vs 2018–2019).

**Results** Medication abortion utilisation increased substantially from 2.9% of all abortions from 2012–2016 to 31.0% in 2018–2019. Abortion after 14 weeks' gestation decreased from 5.8% (95% CI 5.7–5.9) before to 5.3% (95% CI 5.2–5.5) after mifepristone deregulation. Among the 255 642 first-trimester abortions, complications were similar before and after deregulation: abortion-related complication incidence was 0.66% (95% CI 0.62–0.69) before and 0.61% (95% CI 0.55–0.67) after, while severe adverse event incidence was 0.26% (95% CI 0.24–0.28) before and 0.33% (95% CI 0.28–0.37) after (Figure 1). Surgical follow-up was similar in both periods, occurring in 0.05% (95% CI 0.04–0.06) before and 0.06% (95% CI 0.04–0.08) after deregulation. Aspiration/re-aspiration increased modestly from 0.05% (95% CI 0.04–0.06) to 0.13% (95% CI 0.10–0.16), as did ectopic pregnancy diagnosed after the abortion, from 0.15% (95% CI 0.14–0.17) to 0.22% (95% CI 0.19–0.26). Ongoing intrauterine pregnancy continuing to delivery increased from 0.07% (95% CI 0.06–0.08) to 0.31% (95% CI 0.27–0.35) after, while ongoing pregnancy leading to subsequent abortion increased from 0.54% (95% CI 0.50–0.57) to 0.96% (95% CI 0.89–1.03).



**Abstract 4 Figure 1** Incidence of adverse events, abortion-related complications, and ongoing pregnancy outcomes before (2012–2016) and after (2018–2019) mifepristone deregulation in Ontario, Canada among all first-trimester abortions

**Impact** Canada's globally unique deregulation of mifepristone medication abortion, which enabled patients to self-manage their care with their primary care provider's support available, substantially increased medication abortion utilisation and was not associated with a clinically significant increase in abortion complications, ongoing pregnancy, or adverse events.

## 5 DEMAND FOR SELF-MANAGED ONLINE TELEMEDICINE ABORTION IN EUROPE DURING THE COVID-19 PANDEMIC

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**Objectives** In most European countries, patients seeking medication abortion during the COVID-19 pandemic are still

required to attend healthcare settings in person. We assessed whether demand for self-managed medication abortion provided by a fully remote online telemedicine service increased following the emergence of COVID-19.

**Methods** We examined 3915 requests for self-managed abortion to Women on Web (WoW), an online telemedicine abortion service, between 1 January 2019 and 1 June 2020. We used regression discontinuity to compare request rates in 10 European countries before and after they implemented lockdown measures to slow COVID-19 transmission. We examined the prevalence of COVID-19 infection, the degree of government-provided economic support, the severity of lockdown travel restrictions, and the medication abortion service provision model in countries with and without significant changes in requests.

**Results** Five countries showed significant increases in requests to WoW, ranging from 28% in Northern Ireland ( $p=0.001$ ) to 139% in Portugal ( $p<0.001$ ) (Table 1). Two countries showed no significant change in requests, and one country, Great Britain, showed an 88% decrease in requests ( $p<0.001$ ). Countries with significant increases in requests were either countries where abortion services are mainly provided in hospitals or where no abortion services are available and international travel was prohibited during lockdown. By contrast, Great Britain authorised teleconsultation for medication abortion during the pandemic, and remote provision of medications.

**Abstract 5 Table 1** Actual versus expected numbers of self-managed abortion requests in the 'after' period for each country included in the study.

Country	Actual requests (n)	Expected requests (n)	Percentage (%) change over baseline trend (95% CI)	P value
Portugal	34	14.2	139.0 (54.5, 385.7)	<0.001
Italy	53	31.6	67.9 (23.3, 152.4)	<0.001
Hungary	113	83.2	35.8 (11.9, 71.2)	<0.001
Malta	69	52.3	31.9 (3.0, 76.9)	<0.001
Northern Ireland (UK)	97	75.8	28.0 (4.3, 64.4)	0.001
Germany	465	467.1	-0.5 (-9.0, 9.2)	0.798
Netherlands	47	50.9	-7.7 (-28.8, 27.0)	0.458
Great Britain	1	8.1	-87.6 (-92.9, -66.7)	<0.001

**Conclusion** These marked changes in requests for self-managed medication abortion during COVID-19 demonstrate demand for remote models of care, and an urgent need to expand access to medication abortion by telemedicine.