

ABORTION CARE: ENSURING EXCELLENCE, PROMOTING WELLBEING AND IMPROVING TRAINING

'Abortion Care: Ensuring Excellence, Promoting Wellbeing and Improving Training', an online conference jointly organised by the British Society of Abortion Care Providers (BSACP) and the Royal Society of Medicine's Sexuality & Sexual Health Section, was held on 7 October 2021.

The conference comprised presentations by invited speakers and free communications, and the abstracts that follow are from those authors competitively selected to deliver a short presentation of their work during the free communications sessions.

BSACP is 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 is available at <https://bsacp.org.uk>.

1 CO-CREATING ABORTION CARE E-LEARNING

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Introduction An open-source, evidence-based, e-learning package on safe abortion care for healthcare providers (HCPs) and students was co-created with Dr Patricia Lohr, Professor Sharon Cameron, Emma Parnham and 20 volunteer sexual and reproductive health rights (SRHR) Champions from Nigeria, Rwanda, Sierra Leone, Sudan and Zimbabwe as part of the Royal College of Obstetricians & Gynaecologists' Making Abortion Safe Programme (MAS).

Methods The SRHR Champions and UK-based MAS programme team based their approach on the Open University's 'Ideal Model of Co-creation' with its underpinning principles of participation and decolonisation to co-produce the e-learning package. The model consists of three phases:

1. Co-creation and collation of knowledge on the topic: including a rapid review of current resources
2. Co-design of learning: iterative working
3. Co-production of learning.

Results The team worked together between April and November 2021 to produce the first four of eight e-learning modules on:

1. Pre-abortion care
2. Medical abortion before 12 weeks of pregnancy
3. Surgical abortion before 14 weeks of pregnancy
4. Teaching healthcare students about abortion.

The remaining four modules will be completed in early 2022:

5. Medical abortion from 12 weeks of pregnancy
6. Surgical abortion from 14 weeks of pregnancy
7. Managing emergencies and post-abortion care
8. Post-abortion contraception.

Module structure:

- Core tutorial: video lectures with built-in activities
- Additional resources for woman and pregnant people
- Additional resources for HCPs (videos, proformas and more)
- Assessment and certificate of completion.

The benefits and challenges of co-creating culturally sensitive, globally applicable e-learning with over 20 international volunteer HCPs included co-ordinating and considering multiple reviewers' feedback and producing globally recognisable illustrations and accessible language.

Conclusion An international team of HCPs working together in a focused period of time using an iterative, co-design methodology can produce clinical learning resources that are useful and applicable across global contexts. Further information is available from cfwgh@rcog.org.uk.

2 A RETROSPECTIVE OBSERVATIONAL COHORT STUDY OF WOMEN HAVING MORE THAN ONE ABORTION BEFORE AND DURING THE COVID-19 PANDEMIC IN GLASGOW

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Introduction Abortion via telemedicine has been accessible in Scotland since April 2020, with legislation introduced increasing the upper gestation limit from 10 to 12 weeks and permitting home use of both mifepristone and misoprostol, a model demonstrated to be safe and effective.¹ Since the onset of the pandemic there has been no provision for surgical abortions.

Methods A retrospective observational cohort study comparing women having more than one abortion via Sandyford between 1 April 2019 and 1 March 2020 (pre-telemedicine) and 1 April 2020 and 1 March 2021 (delivered via telemedicine) whose first abortion was within the first 6 months for each cohort. Data collected from the National Sexual Health System included demographics, gestation at presentation, pre- and post-abortion method of contraception and type of abortion.

Results Comparing the same time periods there were a total of 1631 and 1777 total abortions, respectively. Of these, 2.33% (n=38, first cohort) had a subsequent abortion within the study dates, compared with 6.44% (n=113, second cohort) having at least one subsequent abortion. For women having more than one abortion, pre-COVID 55.26% (n=21) opted for an early medical abortion at home (EMAH) for their first, increasing to 63.16% (n=24) for the second compared with 90.26% (n=102) of women who had an EMAH following the change in legislation, rising to 93.8% (n=106) for the subsequent abortion. Most women in both cohorts presented <10 weeks' gestation (pre-COVID 89.47% and post-COVID 94.69%).

Conclusions There was a three-fold increase in the number of women presenting for more than one abortion following the introduction of telemedicine and the COVID pandemic. It is not possible to identify reasons for this from this study but it is likely that there are several contributory factors, including socioeconomic factors, access to or perceived access to contraception, and long-acting reversible contraception (LARC) provision. The accessibility and acceptability of the telemedicine model for women seeking abortion is also highlighted.

REFERENCE

1. Aiken A, Lohr P, Lord J, *et al.* Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study. *BJOG* 2021;**128**(9):1464–1474.

3 ABORTION STORIES FROM AFRICAN, CARIBBEAN AND ASIAN PEOPLE IN ENGLAND AND WALES

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Introduction People of African, Caribbean and Asian descent in England and Wales have abortions. In 2020, 209 917 abortion procedures occurred in England and Wales. One in five people who had an abortion were non-white residents of England and Wales: 14 694 (7%) Black, 18 892 (9%) Asian and 8396 (4%) Mixed descent.¹ But the specific abortion experiences of people of African, Caribbean and Asian descent are largely invisible in the current discourse about abortion services in the UK.

Methods Decolonising Contraception conducted semi-structured interviews with 11 people of African, Caribbean and Asian descent. The participants were asked to share their abortion experiences in England and Wales.

Participants were recruited from a social media campaign conducted via Decolonising Contraception's online channels, and from relevant online platforms or channels that primarily catered to an audience of people of African, Caribbean and Asian descent.

The interviews were conducted in compliance with COVID-19 safety measures and were conducted online. The participants were invited to a series of online discussions to share their abortion stories in a group or in a one-to-one interview.

Discussion Although this was a small sample, abortion stories are crucial in challenging the stigma of pregnancy terminations. To challenge the general stigma about abortion, participants were invited to share their experiences of choice, accessibility and safety in procuring their abortions. The majority of participants shared that abortion services were readily accessible and National Health Service (NHS) staff supported their abortion care.

Participants also discussed how cultural, religious and social pressures impacted their decision-making process in receiving abortion care. Most participants articulated the need for more specific and culturally relevant pre- and post-abortion care services, and noted the paramount importance of personal networks in their abortion care.

REFERENCE

1. Department of Health and Social Care. National Statistics: Abortion Statistics, England and Wales: 2020. <https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2020/abortion-statistics-england-and-wales-2020>

4 TREATMENT ADHERENCE AND EXPERIENCE OF SIDE EFFECTS WITH TELEMEDICINE MEDICAL ABORTION AT HOME

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10.1136/bmjshr-2021-bsacp.4

Introduction Legislation was introduced in Great Britain during the COVID-19 outbreak to permit medical abortion at home with telemedicine. In Scotland, following a telephone consultation, eligible women under 12 weeks' gestation were provided with abortion medications for self-administration at home. The aim of this study was to report adherence to the prescribed abortion drug regimen and other provided medications, prevalence of side effects, pain and bleeding.

Methods We conducted a prospective cohort study of 663 women choosing medical abortion at home via telemedicine at the NHS abortion service in Edinburgh, Scotland between 1 April and 9 July 2020. Interviewer-administered questionnaires were completed at telephone follow up on day 4 and day 14 following treatment. Outcome measures were self-reported and included use of mifepristone and misoprostol (date and time), induction–expulsion interval, antiemetic use, antibiotic use, pain scores and analgesia use, rates of side effects, bleeding volume and preparedness for treatment.

Results 636 women (96%) responded to follow-up. 589 (89%) used both abortion medications as directed. The mean (SD) induction–expulsion interval was 4.3 (4.3) hours. Antiemetics were used by 611 women (92%) and 383 women (64%) completed the course of prophylactic antibiotics. 616 (93%) used analgesia, with mean (SD) worst-pain scores of 6.7 (2.2) out of 10.467 (70%) experienced a combination of nausea, vomiting or diarrhoea. 101 (15%) experienced headache. 510 (77%) experienced bleeding that was heavier than a period. 554 (84%) felt prepared for their treatment by their teleconsultation.

Conclusions Patients are able to correctly self-administer abortion medications following a telemedicine consultation. Further research is required to optimise the management of pain and gastrointestinal side effects during medical abortion.

5 CONTRACEPTION USE AND CONTINUATION AFTER TELEMEDICINE MEDICAL ABORTION DURING THE COVID-19 PANDEMIC: AN OBSERVATIONAL STUDY

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10.1136/bmjshr-2021-bsacp.5

Background Changes in legislation due to COVID-19 led to the introduction of telemedicine for early medical abortion (EMA) at home in Scotland. The opportunity to provide contraception at presentation is more limited with this model of

care. Therefore, we wished to compare contraceptive use immediately post-abortion with 3–6 months later to determine if contraceptive needs were being met.

Methods We contacted 579 women who had agreed to be involved in a service evaluation of telemedicine EMA in NHS Lothian at 3–6 months post-abortion. A research nurse administered a questionnaire on their contraception use and future intentions. During this telephone call, women were also offered support in accessing contraception through the abortion service if required.

Results 57.2% (331/579) responded to the contact. 61.6% (204/331) were using an effective method of contraception (hormonal or intrauterine) at follow-up, a significant decrease ($p < 0.00001$) compared to immediately post-abortion (87.9%; 291/331). 41 women (12.3%) accepted the offer of further contraception through this telephone contact, leading to a significant increase in the proportion of women using long-acting reversible contraception (17.6% to 23.7%; $p = 0.0012$). 53.8% (171/318) of women expressed willingness to buy contraceptive pills from a community pharmacy if this were an option.

Conclusions This study suggests that there is a decrease in the use of effective contraception at 3–6 months after telemedicine EMA. Telephone contact at 3–6 months to facilitate obtaining further contraception may be a promising strategy to improve uptake and continuation of effective methods after telemedicine EMA.

6 UPTAKE OF LONG-ACTING REVERSIBLE CONTRACEPTION AFTER TELEMEDICINE-DELIVERED EARLY MEDICAL ABORTION DURING COVID-19

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10.1136/bmjshr-2021-bsacp.6

Background During COVID-19 in Scotland, telemedicine for early medical abortion (EMA) with home use of both mifepristone and misoprostol was introduced. Women wishing short-acting contraceptives could receive supplies in their EMA pack but long-acting reversible contraception (LARC) (implant and intrauterine device) required a subsequent in-person visit. The aim of this study was to assess the uptake of LARC post-EMA during the COVID-19 pandemic.

Methods A prospective observational cohort study of women choosing EMA (<12 weeks' gestation) via NHS Lothian between 1 October 2020 and 28 February 2021. Women were offered post-abortion contraception at initial telemedicine consultation; their selection was recorded in their clinical notes. Those wanting LARC were instructed to book an appointment at a dedicated clinic for post-abortion LARC. We reviewed the regional hospital electronic patient record and clinical databases 6 weeks post-abortion to determine whether women received their chosen method.

Results 944 women received telemedicine EMA. The most popular contraceptive method provided was the progestogen-only pill ($n = 324$, 34%). 300 women (32%) expressed desire for LARC but only 128 (14%) received this method. Nulliparity, gestation over 7 weeks and age under 21 years were all factors positively associated with initiating LARC. Women requiring a pre-abortion, in-person appointment were more likely to have expressed a wish for, and to have received, LARC.

Conclusions Demand for LARC with telemedicine EMA remains high but further research is needed to identify barriers to uptake and to develop interventions to facilitate initiation of LARC with this model of care.