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Addressing the urgent global need for later abortion care during COVID-19 and beyond

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Abortions beyond 12 weeks' gestation comprise the minority of cases globally, namely 10%–40% of all services, depending on country.^{1,2} Later abortions are critical to facilitate as their safe provision can mitigate significant abortion-related mortality and morbidity.¹ People seeking later abortions often face financial and logistical barriers, are more likely to have experienced violence, and be young.^{1,2}

In March 2020, the World Health Organization (WHO) declared COVID-19 a pandemic. Since then, we have witnessed strains on health services, travel restrictions, stay-at-home orders and physical distancing measures to curtail disease spread.³ The resulting disruptions in supply chains, economic instability, interruptions in health services, and fear of seeking treatment have impacted both the need for and access to abortion care, which is considered an essential service by WHO.^{3,4} While all abortion services are essential, ensuring access to later care is crucial given the numerous barriers and delays women face which may be exacerbated by the pandemic, particularly among the most vulnerable and underserved.³

In many settings, particularly low-resource and legally restricted countries, accessing facility-based later abortion care was challenging prior to the pandemic.¹ It has become even more difficult during lockdowns, public transportation stoppages and travel restrictions.³ Strategies to mitigate the COVID-19 impact and maintain or expand access to later abortion care must draw on key innovations, including task-sharing (both provider cadre and facility level), expansion of manual vacuum aspiration (MVA) application, use of telemedicine and accompaniment models, and addressing challenges to commodity supply.^{5–9} Ipas and partners Women on Web and International

Planned Parenthood Federation (IPPF) have for years worked to address these challenges and implement an experience-based response to meet the need for early abortion while simultaneously expanding access to later care using common resources (providers, platforms, commodities and methods). These examples highlight innovative models for expanding access to later abortion care to meet an increased demand for services.

The pandemic has burdened staff and supply chains at referral centres that were previously critical abortion providers.³ Task-sharing among outpatient clinics already offering early abortion services could play a role in expanding the gestational age range for services without requiring referral, as demonstrated by IPPF. IPPF piloted a programme to leverage existing staff and resources to reduce referrals for later abortion from sites offering early services. The pilot implemented a midwife-led medical and MVA outpatient service for abortion beyond 12 weeks' gestation at 18 clinics in six African and Asian countries. The clinics have subsequently served 700 outpatient clients needing later abortion care (mean gestation 14.9 weeks) that would have otherwise been referred to distant, higher-level facilities. IPPF is now incorporating additional innovations to reduce women's in-facility time, including home-administered mifepristone or misoprostol, cervical preparation, and optional home-administration of mailed medical abortion pills. Expanding access to telemedicine abortion may reduce in-clinic demand, allowing other staff time and procedure space for later in-clinic procedures while maintaining physical distancing. Addressing commodity supply includes in-country and regional partnerships with manufacturers and marketing organisations to offset disruptions of centralised supply chains.



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Experience offering services beyond 12 weeks in humanitarian settings, where barriers are significant, provides strategies to expand access during the pandemic.¹⁰ Ipas and partners coordinating reproductive health services during the Rohingya humanitarian crisis found many clients seeking menstrual regulation (missed menses treatment without confirming pregnancy) or emergency services presented with uterine size beyond 12 weeks.¹⁰ Ipas trained and supported physicians to provide post-abortion and indicated abortion care with mifepristone and misoprostol and taught MVA-expansion skills to treat retained placenta and aspiration abortion up to 12 weeks' gestation. Improving the referral network and ensuring providers within and near the camps offered safe, evidence-based care ensured that women had greater access to care. The intervention built provider comfort by expanding the gestational age limit up to 14 weeks for MVA services incrementally, 1 week at a time, for example, from 10 to 11 weeks. The incremental expansion improved provider confidence and ensured sustainability. Training, mentoring and piloting proved critical for provider confidence and reducing stigma with expansion.¹⁰ As the skillset needed for medical management of later abortion and possible complications is similar to obstetrical care, providers already trained in emergency obstetrics gained confidence quickly. During COVID-19, the creation of a virtual provider network may be important for supporting providers unable to meet in person. This work demonstrated that experienced, early abortion providers can efficiently transition to later gestational ages using resources already at their disposal. These providers often need support only for the logistical, legal and structural challenges faced when expanding services.

Telemedicine, as implemented for 15 years through Women on Web's services, illustrates a model which could expand access to non-facility medical abortion.⁶ Indeed in the UK, the expansion of telemedicine has been critical for ensuring the continuity of early abortion services during COVID-19.⁵ Women on Web's service allows people seeking an abortion to consult online with providers to confirm eligibility and receive medication abortion pills via mail. This provision model has been demonstrated to be safe, effective and acceptable by clients at less than 13 weeks' gestation.⁶ A review of Women on Web's provision beyond 12 weeks, in cases where medicines were delayed in arriving to clients, found safe and effective use to 16 weeks' gestation, with an increasing need for treatment from formal health systems as gestational age increased.¹¹ These data are consistent with those published from Latin America and Indonesia, where women in the second trimester received support and accompaniment throughout their abortion process safely outside the health system.⁵⁻⁹

Advocacy for policy changes around gestational age limits should recognise that resources for later

abortion are generally present where early care is available, and that impact on women's lives and health is greater as gestational age increases. The integration of later abortion care into early services is critical for ensuring needed care both during and following the pandemic. Incremental expansion through telemedicine, expanding cadres of providers at lower-level facilities, and providing evidence-based methods while gradually increasing the gestational age range have the potential to significantly reduce barriers to essential abortion care and decrease the stigma associated with abortion services later in pregnancy.

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