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Obstetricians &  
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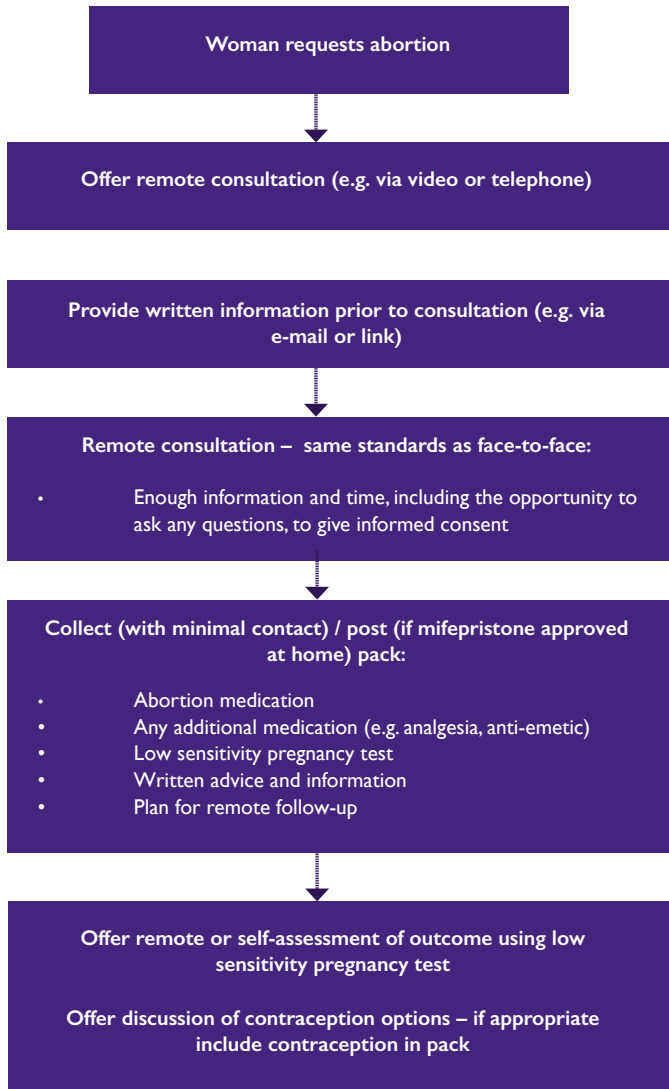
# Coronavirus (COVID-19) infection and abortion care

Information for healthcare professionals

Version 1: Published Saturday 21 March 2020



# Summary of early medical abortion care management during COVID-19 pandemic



## Abortion is essential health care

Services should be organised so as to minimise delays in care

### Ultrasound only when necessary:

- Unable to provide LMP of reasonable certainty within thresholds of eligibility or skill of provider
- History or symptoms suggestive of high risk of ectopic pregnancy such as:
  - o Unilateral abdo. pain and vaginal bleeding / spotting
  - o Intrauterine device in-situ
  - o Prior ectopic pregnancy
  - o History of tubal damage

### No need for routine blood testing

If STI screening indicated or chlamydia test recommended, use remote service (e.g. web-based home testing)

Consent can be given verbally, but discussion must be recorded in notes

Safeguarding assessment needs to be individualised; clinician must be confident woman can speak privately without coercion

Consider other ways to manage available resources and offer woman-centred care:

- Maximise the use of nurses
- For surgical abortion, consider pain relief that does not require theatre facilities or anaesthetic support
- Consider medical abortion in second trimester
- Collaborate with other providers
- Support staff to work from home where appropriate

# I. Introduction

## **Gender**

Within this document we use the terms woman and women's health. However, it is important to acknowledge that it is not only people who identify as women for whom it is necessary to access women's health and reproductive services in order to maintain their gynaecological health and reproductive wellbeing. Gynaecological and obstetric services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

# I. Introduction

The following advice is provided as a resource for UK healthcare professionals and providers based on a combination of available evidence, good practice and expert advice. The priorities are the provision of safe care to women, including those with suspected/confirmed COVID-19. Please be aware that this is very much an evolving situation and this guidance is a living document that may be updated if or when new information becomes available. We therefore suggest that you visit this page regularly for updates.

This guidance applies to women who are requesting an abortion. During the COVID-19 pandemic access to normal healthcare processes will be disrupted. To ensure safe and effective abortion care, greater use of remote consultations and medical abortion at home may be necessary, especially where women and staff may be self-isolating or acute hospital facilities unavailable. This guideline outlines an evidence-based approach to delivering best practice care using well established models that are already widely used, but may have been limited or restricted in UK practice.

This guidance will be kept under regular review as new evidence emerges. If you would like to suggest additional areas for this guidance to cover; any clarifications required or to submit new evidence for consideration, please email [COVID-19@rcog.org.uk](mailto:COVID-19@rcog.org.uk). Please make it clear that your email relates to this piece of guidance. Note, we will not be able to give individual clinical advice or information for specific organisational requirements via this email address.

## I.1 The virus

Novel coronavirus (SARS-CoV-2) is a new strain of coronavirus causing COVID-19, first identified in Wuhan City, China. Other coronavirus infections include the common cold (HCoV 229E, NL63, OC43 and HKU1), Middle East Respiratory Syndrome (MERS-CoV) and Severe Acute Respiratory Syndrome (SARS-CoV).

## I.2 Guidance for people in the UK

Everyone should continue to follow the guidance issued by the UK Government found [here](#).

### 1.3 Regulation of abortion care services

In England and Wales, abortion care is regulated by the Abortion Act 1967 which determines when and where an abortion can take place, and who can provide care. In Scotland abortion is also regulated by the Abortion Act 1967, but responsibility is now devolved to the Scottish Government.

In Northern Ireland access to abortion care is currently minimal, with most women travelling to England in order to access services. The Northern Ireland (Executive Formation etc.) Act 2019 requires the UK Government to introduce regulations for providing abortion care in Northern Ireland by 31 March 2020.

Current law does not permit an early medical abortion service which could be completely provided through remote assessment and mail delivery. A change to allow such remote assessment and mail delivery would align with the government's advice to limit social interaction and travel.

It should be a priority for each of the four nations to consider any emergency legislative or regulatory changes which would enable greater use of telemedicine to deliver abortion care, and ease restrictions on which healthcare professionals are permitted to certify an abortion. Where possible, the four nations should align their approaches to ensure consistency and minimise confusion.

### 1.4 Priority

- **Abortion care is an essential part of health care for women: services must be maintained even where non-urgent or elective services are suspended**
- **Abortion is time-sensitive, and attention should be paid to providing care as early as possible given gestational limits**
- **Organise access to abortion care so that delays are minimised**

Abortion is an essential part of women's healthcare<sup>1</sup>. In England and Wales, 205,295 abortions were performed in 2018<sup>2</sup>, and an estimated one in three women will have an abortion by the age of 45 years<sup>3</sup>. Abortion is safer the earlier in gestation it is done<sup>4</sup>. Mortality and morbidity with abortion is low and lower than continuing a pregnancy to term, but increases exponentially for each additional week of pregnancy after 8 weeks' gestation<sup>5</sup>.

There is evidence that abortion rates are similar whether access to abortion is freely available or restricted, but that where access is restricted women are more likely to resort to unsafe abortion outside of medical regulation which is likely to be detrimental to both them and the healthcare system<sup>6</sup>.

Guidelines from the National Institute of Health and Care Excellence (NICE) on abortion care state that women should be able to self-refer and that there should be minimal delay in the abortion process<sup>7</sup>. This is due to reduced risk of morbidity, the availability at earlier gestations for medical abortion at home, significantly improved cost efficiencies and better patient care.

Delay may mean that gestation thresholds are crossed. Crossing thresholds will prevent women getting early medical abortion at home, will increase demand on operating theatres, and at more advanced gestations will result in more frequent complications, and require specialist skills that already are already overstretched. The impact of not being able to obtain an abortion can be devastating, especially as presentation at later gestations are often from high risk groups, those with significant co-morbidities, or who are seeking termination for reasons of fetal anomaly.

## **2. Pathways to minimise COVID-19 exposure for women and staff**

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- Women self-isolating should be able to collect their treatment package for an early medical abortion from the provider, after remote consultation and with minimal contact. At later gestations, providers should explore if assessment can be done as soon as possible in adequate isolation.
- Self-referral to abortion care is recommended by NICE and can be done remotely
- Maximise the use of remote consultations (e.g. via video or telephone) to deliver pre- and post-abortion care and assessment
- For women requesting an early medical abortion, only require her to attend in person where the benefit of doing so outweighs the risk of COVID-19 exposure and transmission
- Provide abortion care without routine pre-procedure ultrasound
- Provide abortion care without routine pre-procedure blood testing
- If screening for sexually transmitted infections (STIs) is required, offer this remotely (e.g. via a web-based home testing service) when possible
- Offer discussion of contraception options – if appropriate include contraception in pack
- For medical abortion, consider providing a further dose of misoprostol 400 micrograms for use if abortion has not occurred after 3 hours, especially where gestation is likely to be over 8 weeks

Undertaking abortion assessments by phone or video call is recommended by NICE<sup>8</sup> (1.1.9). Providing appropriate information governance safeguards are in place, a client may provide their medical and other history using an online history form transmitted to the provider prior to the consultation.

Consultations can be via video-link or on the telephone, but experience from providers who regularly use telemedicine shows that both women and staff value video-links (see resources below), with solutions that can be delivered from a mobile phone without the need to download additional software being easiest to implement. Providers need to ensure the woman has adequate privacy at the start of the consultation.

### 2.1 Ultrasound scanning

Routine pre-abortion ultrasound scanning is unnecessary<sup>9 10 11</sup>. Most women can determine the gestational age



of their pregnancy with reasonable accuracy by last menstrual period (LMP) alone<sup>12</sup>. A prospective trial of 4,484 women found that only 1.2% of women whose LMP dated them to less than 10 weeks had ultrasound dating of over 10 weeks<sup>13</sup>. The authors noted that even for this group, there is a high likelihood that treatment would be safe and effective.

There is no requirement for an ultrasound to determine gestational age for a doctor to authorise an abortion as meeting the requirements of the Abortion Act 1967; they only have to demonstrate that they are acting 'in good faith'.

Some providers use ultrasound to ensure the pregnancy is not ectopic in location. NICE guidance states that abortion can be performed without definitive evidence of an intrauterine pregnancy<sup>14</sup> (1.7.1). In addition, routine screening of symptom-free women is associated with a high false positive rate when the prevalence of ectopic pregnancy is low, as is the case in the abortion-seeking population<sup>151617</sup>. A history and symptom-based approach, with an ultrasound if indicated, is consistent with NICE guidance on the diagnosis and management of miscarriage and ectopic pregnancy.<sup>18</sup>

A recent multicentre project tested the hypothesis that women with pregnancies at 8 weeks gestation or less can be safely provided with early medical abortion without a routine ultrasound<sup>19</sup>. In total, 365 participants provided enough follow-up information for analysis, in which 95% (n=347) had complete abortion without additional treatment, 1% (n=3) required a surgical aspiration, and 1% (n=3) had a serious adverse event (2 hospital admissions for heavy bleeding managed with aspiration and 1 diagnosis of persistent gestational sac 19 days after enrolment) which were unlikely to have been prevented by conducting a pre-procedure ultrasound. Other studies have provided evidence that early medical abortion can be safely provided remotely up to 70 days' gestation and beyond<sup>20 21 22</sup>.

Reasons for undertaking an ultrasound before abortion in the first trimester include <sup>23 24 25</sup>:

1. If a woman is unable to provide a LMP of reasonable certainty to be able to offer care within thresholds of eligibility or skill (e.g. 10 weeks for an early medical abortion under current regulations, 14 weeks for a vacuum aspiration)
2. History or symptoms suggestive of a high risk of an ectopic pregnancy, for example:
  - Presence of unilateral abdominal pain and vaginal bleeding / spotting which could indicate an ectopic pregnancy<sup>26</sup>
  - An intra-uterine device in situ

- Prior ectopic pregnancy
- History of tubal damage or surgical sterilisation

If a woman has already had an ultrasound, providers should accept the report from other services provided they meet standards of scanning for the UK<sup>27</sup> and not repeat the scan unnecessarily. Ultrasound is not routinely required in the second trimester unless more accurate gestational age determination is needed to plan cervical preparation or other aspects of the procedure or to identify abnormal placentation in women with prior caesarean deliveries.

## 2.2 Blood testing

A robust pre-abortion assessment does not always need to include blood testing. Routine blood tests such as full blood count or testing for haemoglobinopathies are not recommended by NICE<sup>28</sup> and should only be considered if there are specific clinical concerns. It is not cost-effective or necessary to 'group and save' for women undergoing induced abortion<sup>29</sup>.

Determination of rhesus status (RhD) is not required before early medical abortion<sup>30</sup> (NICE 1.3.2). For surgical abortion, NICE guidance recommends this after 10 weeks but only to "consider" determining RhD status under 10 weeks (1.3.3). If having to check RhD status would require an additional visit for the woman, it could be omitted if the risk from COVID-19 outweighs the benefit of receiving anti-D immunoglobulin.

Recent data from flow cytometry suggest that fetomaternal haemorrhage in early pregnancy is less than had been supposed, especially where sharp curettage is not used in surgical procedures. A small study found that of 42 women having a surgical uterine evacuation, none had levels of fetal cells sufficient to cause isoimmunisation<sup>31</sup>. The NICE guidance on miscarriage states that anti-D is not required for medical management of missed miscarriage up to 13 completed weeks(13+6)<sup>15</sup>.

The NICE abortion care guideline noted that assessment for anti-D should be individualised based on an individual woman's risk benefit profile and taking note of women's preferences<sup>7</sup> (evidence review C). For example, anti-D is more likely to be beneficial in later gestations, in young women who are likely to desire pregnancies in the future, and where there would be no delay to their care by testing. In contrast, for same-day procedures where aspiration is used, especially at earlier gestations and where the woman considers her family complete, an assessment may conclude that anti-D is not warranted. If a woman at any gestation is certain that she has completed childbearing and understands the risks of not receiving anti-D then there is no benefit in testing. Overall, should testing be considered necessary, clinicians should discuss the issues with the woman and weigh the risks of COVID-19 transmission, or delay to care that may result, against any benefits of checking her RhD status.

## 2.3 Sexually transmitted infection screening

If a screen for STIs is indicated<sup>32</sup> (or a chlamydia screen recommended as per the national screening programme best practice<sup>33</sup>), a web-based home testing service offers the best solution, although availability will vary owing to commissioning variations.

## 2.4 Early medical abortion

The regimens and process of medical abortion is set out in more detail in the NICE guideline and RCOG, FSRH and BSACP Clinical Guidelines for Early Medical Abortion at Home – England<sup>34,35</sup>. Effective regimens for medical abortion include:

- Mifepristone 200 mg orally, followed 24–48 hours later by misoprostol 800 micrograms given by the vaginal, buccal or sublingual route
- If abortion has not occurred, a further dose of misoprostol 400 micrograms after 3 hours can be administered<sup>36</sup>. Providers should consider providing this to women at the outset

Assessment of post-medical abortion outcome should be delivered with the use of a low sensitivity pregnancy test<sup>37</sup> (NICE 1.14.2). Women should have the choice of self-assessment, or remote assessment (for example telephone or text messaging), as an alternative to clinic follow-up<sup>38</sup> (NICE 1.14.1). If low sensitivity pregnancy tests become unavailable, a high sensitivity pregnancy test may be used 3-4 weeks after treatment<sup>39,40</sup>.

Mifepristone must currently be administered on premises specifically licensed for abortion care. However, misoprostol has been authorised for home use, and providers should consider packaging the other medicines needed for medical abortion (i.e. misoprostol, any additional analgesia or anti-emetic indicated), a low sensitivity pregnancy test (with instructions for use), written advice and plan for remote follow-up or self-assessment. The woman can collect the package with minimal contact from a reception area following assurance of identification. Should 'home' be later authorised as a class of place where mifepristone could be provided, both mifepristone and misoprostol could be included in a package to be picked up or medications could be sent by mail or courier.

Women should be given the option to discuss contraceptive options. Offer to include a method of contraception in the treatment pack. Consider whether restrictions on travel and primary care will impact on a woman's ability to obtain contraception and whether the progestogen-only pill is appropriate.

### **3. Consent and safeguarding with remote consultations**

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- The woman must be given enough information and time, including the opportunity to ask any questions she may have, so that she can give informed consent to proceed with the abortion
- Written information should be provided or available prior to the consultation; this can be e-mailed, or a link provided to an online source
- Consent does not have to have a written signature, but an entry must be made in the clinical notes that the woman has given informed consent
- Safeguarding is an essential part of the assessment for abortion care, but where a more detailed assessment is required individualised judgement should be used to determine whether remote consultation is suitable

The process of obtaining consent should follow normal best practice as detailed in GMC guidance<sup>41</sup>. This should include the information discussed; any specific requests by the woman; any written, visual or audio information given to the woman; and details of any decisions that were made. The consent must be recorded in the woman's medical records and include the key elements of the discussion with her, but it does not have to be on a specific form or signed by the woman – patients can give consent verbally<sup>42</sup>. Consent can be obtained remotely using telephone, internet or video link providing that it is appropriate to the woman and meets the same standards for content as would be undertaken in a face-to-face encounter<sup>43</sup>.

The RCOG state in their guideline "Obtaining Valid Consent"<sup>44</sup>,

*"It is a common misconception that consent has to be written for it to be valid. A key issue in taking consent is the recognition of the fact that consent is a process that involves supplying the patient with enough information to make a fully informed decision. Therefore what matters is not necessarily the completion of a form but during the process of taking consent that the medical records contain clear, concise notes that cover the nature of the procedure concerned, risks, benefits and alternatives, along with a record of fears or concerns raised by her."*

Safeguarding is an essential part of the assessment for abortion care, and providers should follow their processes and assess each case on an individual basis. However there is no automatic need to have to do this in person if adequate assessment is possible via remote consultation, although it is recommended that this should be tailored to the individual<sup>45</sup>. The clinician should be confident that the woman is not being coerced and that she is able to discuss any concerns privately.

## **4. Other pathways to manage resources and workload**

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- Maximise use of nurse delivered care within the constraints of the current legal framework
- Consider surgical abortion with access to pain relief that does not require theatre facilities or anaesthetic support
- Consider extending services for medical abortion to the second trimester

For women who are beyond the threshold for an early medical abortion (up to and including 10+0 weeks) or who request vacuum aspiration, there are a number of other considerations which can be made.

Nurses safely and effectively provide abortion care in many healthcare settings around the world and there is evidence that such care is preferred by women<sup>46</sup>. Their role is supported by the NICE abortion care guideline (1.1.1.1).

Surgical abortion can be safely delivered outside of an operating theatre, and without requiring anaesthetic support, by using effective local anaesthetic techniques (e.g. paracervical block)<sup>47 48</sup>, conscious sedation or intravenous sedation<sup>49 50 51</sup>.

Medical abortion regimens using 200 mg oral mifepristone and misoprostol are effective and appropriate at any gestation<sup>52 53</sup>. Many Trusts only offer medical abortion in the second trimester for termination in cases of fetal anomaly. However, if theatre capacity becomes increasingly restricted, services should consider retaining or expanding access to second trimester abortion services for all women.

Second trimester medical abortions can be completed as day cases when the interval between mifepristone and misoprostol is 36-48 hours (mean induction to abortion time of 6-8 hours)<sup>54</sup>. Feticide is recommended at 22 weeks (22+0) or greater<sup>55</sup>; this should be facilitated collaboratively with fetal medicine services.

Safeguarding is an essential part of the assessment for abortion care, and providers should follow their processes and assess each case on an individual basis. However there is no automatic need to have to do this in person if adequate assessment is possible via remote consultation, although it is recommended that this should be tailored to the individual<sup>56</sup>. The clinician should be confident that the woman is not being coerced and that she is able to discuss any concerns privately.

# 5. Collaboration



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- Abortion providers should collaborate and support each other to ensure available resources are used most effectively
- Commissioners should ensure there are no barriers to collaboration and shared care pathways
- Where an abortion provider has to temporarily suspend services (e.g. to permit deep cleaning) they should alert nearby providers and where appropriate organise transfer of care of existing patients
- Wherever possible, providers should recognise the processes and documentation of providers transferring care or seconding staff to them (e.g. assessments, safeguarding outcomes, consent forms, staff accreditation and credentials) to minimise duplication of work

Most abortion care in the UK is delivered by the independent sector providers (ISPs): the British Pregnancy Advisory Service (BPAS), Marie Stopes International UK (MSI) and the National Unplanned Pregnancy Advisory Service (NUPAS).

ISPs mostly deliver care from community centres and therefore cannot manage complex cases or those that need the resources of an acute hospital (e.g. overnight admission, high dependency care, laboratory facilities). However, by offering care outside of NHS Trusts they can relieve pressure on hospitals, they have efficient systems that include long-established centralised telephone assessment pathways and have experienced nursing and medical staff who can operate up to 23+6 weeks.

Acute Trusts, faced with pressure on their beds and operating theatres, may consider collaborating with ISPs to transfer non-complex cases to their care or identify ways to share facilities or staff. This may help the Trust concentrate its resources on maintaining essential provision to women who must have care in hospital, such as those requiring isolation owing to COVID-19 or who have existing co-morbidities. Although emergency transfers following complications from the ISPs to the acute sector are rare, they do inevitably occur given the high volumes. Therefore, maintaining an emergency gynaecology service with the capacity to admit is essential.

## 5.1 Considering transfer of care to independent sector providers

- If the woman has not yet had care, she can be directed to the website or phone number of the ISP who may be able to organise direct access for her
- If the provider has seen the woman, they should phone the ISP making it clear they have already assessed the woman (as that should prevent the need for another appointment); relevant documents (e.g. clinical notes, HSA1 form, scan or laboratory reports) should be sent electronically as directed by the ISP

The contact details of the ISPs are:

BPAS

T: +44 (0) 3457 30 40 30    W: [bpas.org](http://bpas.org)

MSI

T: +44 (0) 808 503 6859    W: [mariestopes.org.uk](http://mariestopes.org.uk)

NUPAS

T: +44 (0) 333 004 6666    W: [nupas.co.uk](http://nupas.co.uk)

## 6. Staffing issues

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- **Staff who need to self-isolate but who are otherwise well and able to work should be supported to work from home**

Where IT systems permit remote access, staff may be able to work from home in a range of activities that may include remote patient care, for example telephone consultations and checking and signing statutory forms or remote prescribing. Providers should ensure their IT policies regarding remote access are clear, and where possible should facilitate this.

The prescribing of medication to procure an abortion is controlled by the Abortion Act 1967, and current restrictions on prescribing may be amended depending on the terms of any emergency regulation issued by government.

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# Additional resources

Support, advice and resources are also available from:

British Society of Abortion Care Providers (BSACP) – [www.bsacp.org.uk](http://www.bsacp.org.uk)

IPAS – [www.ipas.org](http://www.ipas.org)

World Health Organization (WHO) – [www.who.int/health-topics/abortion](http://www.who.int/health-topics/abortion)

Webinars from experienced practitioners delivering remote care are available (with thanks to and courtesy of BSACP and Gynuity):

Abortion without prior ultrasound – <https://bit.ly/2xFeboC>

Video consultation in abortion care – <https://bit.ly/2Oohd7b> (access code: GH207)

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