BUILDING THE CASE FOR REPRODUCTIVE CHOICE

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Abbreviations

PS: Plenary session
CS: Concurrent session
AB: Essentials in abortion care
LS: Lunch session
FC: Free communication
P: Posters

Plenary sessions

PS3.2

Observational trials, what are they showing in Moldova & challenges of the once-a-week pill

Rebecca Gomperts, Women on Waves, Netherlands

Abstract

The presentation will present the results of the research on mifepristone 50 mg as a once-a-week contraceptive that Women on Waves and Karolinska Instituted have been doing in Moldova for a year.

PS3.6

What women want

Clare Murphy, Feed, United Kingdom

Abstract

Current regulatory frameworks generally draw a line for where contraception ends and abortion begins, with methods that act from implantation deemed to be abortifacients, with significant implications for the way in which they can be provided. However, while this line may act as a boundary at a legal, regulatory, and service level, there is little understanding of the significance of this boundary to women themselves, and their willingness therefore to routinely use methods that act in this space and which may have both contraceptive and abortifacient properties. This question has become increasingly urgent as more women appear to reject existing hormonal contraceptive methods, based on real or perceived risks; the prospect of legal reform that could change the current regulatory boundaries becomes more likely in the UK at least; and a body of research is developing to support the clinical reality of a “contragestive” which women could use less frequently than existing methods or in an as-needed fashion. This paper looks at data on women’s views on both existing and future methods and their mode of action, and critically, what they actually want.

PS4.1

Person-centred abortion care: global

Angela Dawson, University of Technology Sydney, Sydney, Australia

Abstract

This plenary presentation will explore best practice models of person-centered abortion care. This moves us from authoritative pathogenic-focused care or personalized medicine, where the patient is provided with an intervention and educational materials, to patient-centered care, where people are engaged in conversations, to inclusive person-centered involving the co-design and co-production of services.

PS4.5

Post-Abortion Care in Restricted

Joyce Sakala, Zambia

Abstract

Africa has the highest rate of maternal deaths due to unsafe abortion. Although more countries have permissive abortion laws, challenges such as access, knowledge of the availability of safe abortion, and provider attitudes and beliefs contribute to challenges faced by women to access the service. My presentation will focus on sharing some of the initiatives to address the challenges to provide equitable abortion care in restricted settings.

Concurrent sessions

CS2.1

How to deal with disinformation about hormonal contraception

Christian Fiala, MD, PhD, Gynmed Clinic, Vienna, Salzburg, Austria

Abstract

Objective:

Today a human dream has come true: we are able to effectively separate fertility and sexuality. Since the 1960s we have had an unprecedented high number of highly effective contraceptive methods at hand. Their introduction led to a decrease in unwanted pregnancies and thus a decline in abortions. However, this decline came to a halt around 1995. Since the rates remain stable or even increase in countries with reliable abortion statistics. How can this be explained and is there anything to do?

Methods:

Analysis of historical and current published scientific literature on contraception and putting it into context.

Results:

Under natural conditions, women have around 15 pregnancies during their 35 years of fertility on average. For most women and their partners, this has always been far too many.

Therefore, humans tried to limit natural fertility to the individually desired number of children since the first days of humankind. However, this has been highly ineffective until several milestones happened in the last century:

- the discovery of the fertile days by Knaus and Ogino
- the development of the 'Pill', which was financed by two women in their menopause
- development of several effective and safe IUDs

35 years after the marketing of hormonal contraception the "Pill Scare 1.0" took place in 1995. In 2012 the "Pill Scare 2.0" started, is still ongoing and there is no end in sight. The current pill scare consists of continuous negative media reports about hormonal contraception, it ignores the huge benefits they can have and is mainly based on emotional reporting or correlation of side effects of the pill, most of them without proof of causation. Importantly, none of these negative reports offer a constructive solution for women nor do they give women an alternative effective contraceptive option for the 35 years of their fertile life. Also, the many important non-contraceptive benefits of hormonal contraception are widely underreported. This negative reporting of the pill in scientific and lay media has had no documented positive impact on women but led to a significant reduction in the use of (effective) hormonal contraception and subsequently a high level or even an increase in abortions. Furthermore, the pill scare media campaign strengthens the wrong belief of natural monthly bleeding. By this not only the many side-effects and the widespread suffering of women

ignored but also the empowering information that women can self-decide whether and how many menstrual bleedings they have.

Conclusions:

Women really have only two options for handling their 35 years of fertility: either they control their fertility or fertility controls their life. The current public discourse which leads away from hormonal methods towards 'natural contraception' is basically fear-driven and mostly in contradiction to facts. However, it leads many women to use less effective or no methods with the inherent risk of unwanted pregnancies and abortions.

The question arises whether we as HCPs should let that happen or whether we should develop counseling strategies to help women overcome the fear-driven media messages so that each woman can find the method that protects her best and is best tolerated by her, eventually even having additional non-contraceptive benefits. If we want to counterbalance the media message, we could inform women that hormones are neither good nor bad but simply the 'language of the body'. Therefore, hormones represent the most effective method of reversible contraception. They enable women to exert full control over their reproduction so that they have children and menstruation by choice, not chance."

CS2.3

Effective use of 'natural methods

Kristina Gemzell–Danielsson, Karolinska Institut, Stockholm, Sweden

Abstract

There is no clear definition of "Natural methods" but this may refer to non-hormonal or "hormone-free methods" or "Fertility awareness-based methods (FAM)". Among these, there is one method that has received FDA clearance, the Natural Cycles app.

Currently, the main reasons for discounting hormonal contraception stated in surveys on contraceptive use are unscheduled bleeding and mood and/or libido changes. Fertility tracking apps are part of a larger movement towards wellness and body awareness and may be good educational tools. However, as they are FAMs of contraception, they cannot be expected to be more effective at protecting against unintended pregnancy, abortion, and unintended birth than available hormonal contraceptives;

Natural Cycles relies on basal body temperature with a basal body thermometer OR skin temperature through integrated wearable devices. Currently Natural Cycles is cleared by regulators to take temperature input data from the Oura Ring and Apple Watches with temperature sensors. To achieve ""perfect use"" and get maximum effectiveness from the app, the user must abstain from unprotected sex during red (fertile) days.

Combining digital birth control with wearable devices removes the burden of manual symptom verification, improving both retention rates and typical use effectiveness significantly. Perfect use effectiveness and algorithm performance is unchanged, as the temperature measurements from either device have been shown to be substantially equivalent.

A trade of from using less effective but more accepted method may be improved compliance and typical use effectiveness. However, so far there is no research comparing the Natural Cycles app to hormonal birth control in scientifically rigorous clinical trials. Additionally, FAMs, such as the Natural Cycles app, do not protect against sexually transmitted infections and provides no hormonal added health benefits.

CS3.2

Very early abortion with uterine aspiration: pros/cons and patient access implications

Maureen Baldwin, Oregon Health & Science University, Portland, Oregon, USA

Abstract

While there is a growing reliance on patient-reported gestational dating for medication abortion, there is an increasing scrutiny on work-up and evaluation of non-visualized pregnancy either before or after aspiration abortion. Very early aspiration abortion has similar rates of effectiveness and safety compared to very early medication abortion. Benefits of aspiration abortion include potential for sooner completed abortion, lower cost, less need for follow-up, and shorter duration of pain and bleeding. Potential drawbacks of very early aspiration abortion include uncertainty about pregnancy location, uncertainty about completed abortion with difficulty visualizing gestational tissue in the uterine aspirate, leading to increased follow-up need, and advice for further clinic visits, which may be a challenge to privacy and cost. We will review clinical guidance prior to aspiration abortion, and implications for abortion access and safety.

CS4.4

Abortion is a Fact of Life in Modern Malta

Isabel Stabile, University of Malta, Msida, Malta

Abstract

“Please help me. I am pregnant and I can’t tell anyone what is going on or they might stop me. I can’t continue this pregnancy and please I’m so scared.”

"I am pregnant and I need an abortion. I have one child and can’t afford to have another one. Please help me.""

Every time someone resorts to calling me a “murderer” and a “shredder of babies” or some such nonsense, all of which is a regular occurrence in Maltese online discourse, it is an admission that they have no argument whatsoever. Rather than criticize me and the organization I represent for wishing to allow women the choice of what happens after they become pregnant, perhaps they should reflect on the privileged position from which they state unequivocally that the introduction of abortion in Malta is an “evil step”.

Whatever others may believe, my colleagues and I do not “shred babies”, because (1) the vast majority of the 500 or so abortions taking place in Malta each year are medical abortions; (2) before birth we refer to a fetus; it’s only a baby after birth which is when it derives its rights. Women who

are happy to be pregnant will use the same term, but those who are not, do not; (3) providing information about safe and accessible abortion methods is not against the law; and (4) although every doctor has the right to choose not to provide abortions, part of their duty to care for every woman is the requirement to refer appropriately.

Moreover, our sexual and reproductive health helpline, received more than 1200 calls since its inception over the past two years, with people asking questions about contraception, the morning-after pill, and also abortion. All have received objective, unbiased, and non-judgemental advice. It is a shame that our country ignores their needs and that our volunteers have to make up for the failure of the state.

Criminalizing abortion puts lives at risk because people will access abortion care regardless of what the law says. Forcing someone to give birth against their will by removing from that person the possibility of being true to their moral beliefs in their own lives makes no sense at all to me. I have never had an abortion myself, nor have I ever performed one, but I believe there is a strong moral case for freedom of reproductive choice and there should be nothing stopping any person from choosing to have an abortion.

CS6.1

Pain management with IUD insertion

Anne Verougstraete, VUB, Belgium

Abstract

The fear of pain can be an obstacle for women who are interested in IUDs as a contraceptive method. A minority of women experience severe pain and social media spreads the news!
As IUDs are among the most effective methods, everything should be done to eliminate pain and fears at the insertion of the IUD.

Women without a vaginal birth, women with painful menses, and who previously had difficult IUD insertions will experience more pain. It is essential to take into account the history and fears of each woman and to discuss how we can help her best.

We will discuss the possible problems and the efficacy of medication taken before fixing the IUD, different types of local anesthesia, hypnotic techniques, and sedation."

CS6.2

Conscious sedation

Patricia Lohr, British Pregnancy Advisory Service, London, United Kingdom

Abstract

General anesthesia for first-trimester surgical abortions is not routinely recommended due to its safety risks and financial costs. Low-dose intravenous midazolam and fentanyl to achieve a state of conscious sedation is listed in (inter)national guidance as an alternative to general anesthesia or local cervical anesthesia alone. This talk will review the evidence for conscious sedation in surgical

abortion care and describe the implementation of operator-delivered conscious sedation at the British Pregnancy Advisory Service, outcomes over 5 years, and lessons learned.

AB1.1

Basics of a pre-abortion consultation and respectful care

Jayne Kavanagh, UCL Medical School, London, United Kingdom

Abstract

Inspiring the next generation of abortion care providers and future abortion champions

Background
In 2012 the Royal College of Obstetricians and Gynaecologists (RCOG) released a statement outlining their concerns about the future UK abortion workforce. Junior doctors, they claimed, no longer wanted to work in abortion care, which would ultimately lead to a crisis in provision in the following decades.

Objectives
To analyse a range of activities, motivated by this statement, designed to inspire the next generation of UK abortion providers and future abortion champions.

Method
The following activities were analysed:

1. The design and delivery of comprehensive and inclusive core medical school teaching on abortion.
2. The development of medical school abortion-related voluntary courses and extra-curricular activities.
3. A national Curriculum Champions project that worked with stakeholders to improve medical education on abortion throughout the UK.
4. The implementation of Doctors for Choice UK (DfCUK) strategy to recruit younger members.

Results
96% of students rated the improved abortion teaching as 'important', regardless of their attitude to abortion. Drawing on the comprehensive and inclusive teaching resources, the Curriculum Champions project has improved medical school teaching on abortion in at least 16 UK medical schools.

Student membership of Doctors for Choice UK went from zero to 76 following the implementation of its strategy to recruit younger members. 50% of the current DfCUK committee and 10% of Community Sexual and Reproductive Health trainees attended the medical school with the most comprehensive abortion teaching and widest range of abortion-related extra-curricular activities.
Conclusion

In order to inspire the next generation of abortion care providers it is essential to deliver comprehensive medical school abortion education. Giving medical students access to abortion-related voluntary courses and extra-curricular activities, and involving them in abortion advocacy, helps inspire future abortion champions.

AB3.1

Historical perspective - vacuum aspiration

Bojana Pinter, University Medical Centre Ljubljana, Slovenia

Abstract

The history of surgical abortion is deeply rooted in medical advancements, legal battles, and social attitudes. Early forms of abortion, including surgical methods, were practiced in ancient civilizations, but these were often unsafe and lacked medical standardization.

In the 20th century, the political landscape began to shift regarding reproductive rights. A key moment was the legalization of abortion in the Soviet Union under Vladimir Lenin in 1920, making it the first country to do so on a broad scale. Lenin's government viewed abortion as a necessary medical procedure in the context of women's liberation, aligning with their broader socialist principles. With the legalization of abortion medical doctors in the Soviet Union were able to search for safer techniques of abortion, to prevent unnecessary deaths of women.

Advancements in surgical techniques, especially vacuum aspiration, made abortions safer. The vacuum aspiration technique was developed in the Soviet Union in China and improved in Slovenia (then part of Yugoslavia) in the 1960s. A critical development in the study and practice of abortion occurred with the Ljubljana Abortion Study carried out in Ljubljana, Slovenia in 1971-1973. This comprehensive research examined the safety of surgical abortion, especially vacuum aspiration, contributing to the growing medical consensus that, when performed correctly, surgical abortion was a safe procedure. The study also supported the argument for liberalizing abortion laws, which influenced policies in Eastern Europe and beyond.

The development of safe abortion techniques accelerated the recognition of family planning as a basic human right. The UN Tehran Declaration on the right to family planning was a significant outcome of the International Conference on Human Rights held in Tehran, Iran, in 1968. This declaration recognized the right of couples to decide freely and responsibly on the number and spacing of their children, marking a pivotal moment in the global acknowledgment of reproductive rights as a fundamental human right.

Non-Aligned Movement (NAM) countries, including Yugoslavia, India, and Egypt, played an essential role in advancing this agenda. These countries, which were neither aligned with the Western nor Eastern blocs during the Cold War, championed the right to family planning as a critical component of social and economic development. They argued that population control was vital for improving living standards and reducing poverty, which resonated with their broader goals of promoting self-determination and social justice. Yugoslavia and India, in particular, were leaders within NAM, advocating for policies that empowered individuals through access to reproductive health services. Egypt, with its significant population challenges, also supported these initiatives, aligning family planning with national development goals. The Tehran Declaration thus reflected a global consensus, shaped significantly by the advocacy of these non-aligned nations, on the importance of reproductive rights.
Today, surgical abortion still remains a critical aspect of reproductive healthcare, though access and legality vary widely across the globe, shaped by historical precedents, including Lenin's policies, NAM, Tehran declaration and research like the Ljubljana Abortion Study.

AB3.2

Vacuum Aspiration and Comprehensive Pain Management in Surgical Abortion

Christian Fiala, MD, PhD, Gynmed Clinic, Vienna, Salzburg, Austria

Abstract

Abortions have been performed for around 100 years. But most methods were dangerous and ineffective during the time it was illegal. Major improvements took place with the legalization of the procedure. Since many improvements have been developed making abortion one of the safest procedures in medicine. However, implementation of improvements has sometimes been slow and still is.

Surgical abortion is now being done using a plastic aspiration canula. The diameter corresponds roughly to the gestational week. Cervical priming with misoprostol or mifepristone facilitates cervical dilatation and reduces the risk of perforation or laceration. For dilatation, conically shaped dilators should be used instead of the still frequent use of Hegar. No (sharp) curettage is needed to verify that the uterine cavity is empty. However, an abdominally performed ultrasound examination done at the end of the aspiration is very helpful to diagnose remaining tissue and remove it immediately. The procedure can be performed either under local anesthesia (intra-cervical instead of para-cervical) or using a very short-acting general anesthesia.

It would improve women's health status and we would reduce complications significantly if we as clinicians would perform abortions based on the available evidence and integrate these findings into current practice. This would also reduce medical supervision and give women more autonomy in the abortion process.

Finally, political decisions are needed to reduce all restrictions in access to abortion as they have shown to be counterproductive. Abortions need to be freely accessible for all women.

AB3.3

Dilatation and evacuation

Ed Dorman, NHS, London, UK

Abstract

Second-trimester surgical abortion (D+E) is, in most circumstances, the safest method of abortion from 14 through 24 weeks gestation and (in skilled hands) even beyond that time. Where choice is offered to patients, D+E is often the strongly preferred method of abortion. The skills required to provide D+E are not difficult to acquire but lack of access to training is a major problem in many countries. Surgical skills in D+E procedures are transferable and can be life-saving in the context of mid-trimester pregnancy complications in maternity care. Abortion services should offer a choice of method including D+E to their patients and all Obstetricians should be trained and able to undertake uterine evacuation by D+E when this is required.

Lunch sessions

LS1.1

VEMA (Very Early Medical Abortion) - Results from the First Large Randomized Controlled Trial

Kristina Gemzell–Danielsson, Karolinska Institut, Stockholm, Sweden

Abstract

Background:

Evaluating the efficacy and safety of very early medical abortion (VEMA) before confirmed intra-uterine pregnancy (IUP) is urgent due to medical, economic, psychological, and legal reasons. There are no randomized controlled studies (RCTs) comparing VEMA to delayed (standard care) abortion. Observational studies have shown conflicting results with regards to efficacy.
Methods: We conducted a multicenter, randomized, non-inferiority trial including women requesting medical abortion up to 42 days of gestation, with a non-confirmed IUP on ultrasound examination (an empty cavity or a sac-like structure without a yolk sac or embryonic pole). Participants were randomized to either immediate start of abortion (VEMA) or standard care treatment delayed until IUP was confirmed. The primary outcome was complete abortion. The non-inferiority margin was set at 3% for the upper limit of the confidence interval (CI) for the absolute risk difference.
Results: We included 1504 women randomized to early start (n=754) or standard care (n=750). In an intention-to-treat analysis, 676/710 (95.2%) of participants randomized to early start and 656/688 (95.4%) of participants randomized to standard treatment had a complete abortion; the risk difference (standard vs early) was 0.1% (95%CI -2.1,2.3). The ectopic pregnancy rate was 1.10% with no significant difference between groups.

Conclusion:
The efficacy of VEMA is non-inferior to medical abortion at confirmed IUP and should be offered to women seeking abortion in very early gestation. Women should be informed of the importance of assessment of treatment outcomes with s-hcg.

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LS1.2

Rhesus Prophylaxis (Anti-D) in Early Abortion – Where is the Evidence?

Christian Fiala, MD, PhD, Gynmed Clinic, Vienna, Salzburg, Austria

Abstract

Objective:

Determining the blood group prior to an abortion is done in most places in Europe and North America because we want to find those women who are rhesus negative and give them an Rh-immunoprophylaxis to prevent sensitization and subsequent hemolytic disease of the fetus and newborn. However, there is no evidence for the need of Rhesus-prophylaxis in first trimester abortion and most recommendations do not cite any evidence.

Methods:

- Analysing basic data
- Systematic literature review in an effort to update evidence-based recommendations
- Analysis of current guidelines on anti-D prophylaxis in early abortion
- International survey among abortion provider's practice

Results:

Rhesus negativity is a Caucasian trait (15% in Europe) usually not found elsewhere. Transfer of 1ml foetal blood into the female blood circulation is needed to induce sensitization. Total foetal blood volume is around 0.8ml at 8 weeks gestation and 4.2ml at 12 weeks. Foeto-maternal blood transfusion seems unlikely, given the small amount of foetal blood. Especially in very early pregnancy.

A Systematic Literature Review confirmed a lack of evidence supporting Rh- IgG administration in first trimester abortion. On the other hand, it is inherently difficult or even impossible to proof there is no need. Even when the existing literature clearly points in that direction. Interestingly, the existing guidelines vary considerably in their recommendations, mirroring the lack of evidence.
An international practice survey revealed that more than half of providers routinely administer IgG anti-D to all Rh-negative patients in the first trimester, 19% to some, applying various individual criteria and 19% to none. 42% of providers who give anti-D give an unnecessarily high dose which is sufficient to neutralize 30ml of foetal blood. The others give various doses. However, 60% of these providers are interested in changing their practice.

Conclusions:

The available evidence clearly indicates that giving Rh-IgG in first-trimester abortion is not necessary because there is no risk for Rh-sensitization. However, most providers still give Rh-IgG to all or some of their patients.

Abortion would be easier and more convenient if Rh-prophylaxis is not given and therefore no need to determine the blood group in all patients. This is especially true for medical abortion, where this is the only invasive act. The procedure would also be less expensive and women would avoid a potential health risk by avoiding Rh-IgG of human origin.

LS2.1

"How far is too far?" Creating an evidence base for the safe provision of abortion among people living far from emergency services.

Wendy V. Norman[1], Amanda Cleeve[2], John Reynolds-Wright[3], Danielle Mazza[4], Sharon Cameron[3], Kristina Gemzell-Danielsson[2]

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Abstract

Background:
Countries with remote populations face rural-urban abortion access inequities. Rural and remote provision of medication abortion (MA) could potentially improve access and reduce inequities. Most current guidelines restrict MA to those with immediate access to emergency services such as transfusion and surgery. Although a rare MA complication (1.4/1,000), the need for transfusion may be driving recommendations that limit rural-remote MA provision. Our systematic review demonstrated that the proportion of post-MA transfusions that are emergencies, the risk factors for and transfusion timing after MA are all unknown.

Objectives:
We will build an evidence base to address this important global gap in abortion guidelines. We will define the associated urgency, timing, and risk factors for post-MA transfusion and will engage people in rural-remote areas and their health care providers (HCP) for their context and perspectives.

Methods:
We designed a four-country (Canada, Scotland, Sweden and Australia) study to determine these unknowns. We will conduct a retrospective chart review case-control study to understand urgency and risk factors for post-MA transfusion; analyze population-based health administrative data to understand incidence, timing, and associated health care events; conduct interviews with rural-remote patients and their HCP to register preferences and trade-offs for provision of abortion care for rural-remote populations.

Results:
We have received funding and ethics approval. At this session we propose to discuss the project aims, activities, and progress, and to engage audience members' opinions, suggestions and expertise to inform data collection, interpretation, and next steps to ensure high quality evidence to support clinical practice guidelines.

Conclusions:
First trimester MA carries a very low risk of transfusion. To support provision of safe first trimester MA particularly among people living far from emergency services, there is an urgent need to investigate the timing of prodromal signs, degree of emergency, and risk factors for post MA transfusion.

Free communications

FC01

Abortion access for underserved groups: a national program to support health care professional practice

Professor Wendy V. Norman[1], Dr. Fatawu Abdulai[1], Dr Stephanie Begun[2], Dr. Martha Paynter[3], Professor Sharon Cameron[4], Dr. Patricia Lohr[5], Professor Danielle Mazza[6], Professor Kristina Gemzell-Danielsson[7]

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Abstract

Background and Objectives: Access to abortion is challenging for equity-deserving populations. Canada's government called to improve tools for healthcare professionals (HCPs) to provide accessible, high-quality care for underserved groups. Our team developed "The CART Access Project" to address this call.

Methods: The CART Access project engaged representatives from underserved groups, leaders of physician, nursing, midwifery and pharmacist HCP organizations and an International Advisory Committee from February 2023 to March 2024. We performed needs assessments, reviewed practice standards, created new HCP curricula, continuing professional development sessions, and mentorship and other resources including pragmatic practice tools. We convened for a national summit in Ottawa Feb 2024 to support dissemination and sustainability.

Results: We developed a national open-access virtual community of practice for abortion HCPs on the Society of Obstetricians and Gynecologists of Canada website. Each HCP discipline hosted their discipline-specific resources on their own sites and cross-linked to other project resources. Exemplars include new curricula for pre-licensure nursing and midwifery training; a range of continuing interdisciplinary professional development courses, webinars, and pod casts; regional mentorship hubs across the country providing any abortion-provider HCP real-time access to an abortion care expert; and a range of practice tools (discipline specific and cross-disciplinary) informed by underserved groups to ensure appropriate, considerate, welcoming service design and implementation across HCP groups. Project partners found high value and productivity through the process of working between national disciplines, and engaging national and international experts, across the project.

Conclusions: The CART Access Project convened all relevant national healthcare professional organizations in Canada together with abortion experts and underserved people with lived experience. Together we developed a range of tools to improve equitable access to abortion in Canada. Networking connections, curricula, educational resources and practice support media are now available to improve high quality, equitable abortion care.

FC02

The Repro Uncensored coalition : Fighting digital suppression of abortion information

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[1]Women on Web, Toronto, Canada. [2]Women First Digital, Lyon, France. [3]Plan C, Brussels, Belgium. [4]Amnesty International, Washington, USA

Abstract

Big Tech and governments increasingly suppress abortion information on social media and search engines, hindering global access to essential healthcare. The Internet is crucial for SRH, and the pro-abortion movement needs tech companies to ensure accurate, quality information is available. Instead, digital suppression and disinformation are rising, negatively impacting those seeking or advocating for safe abortions.

In March 2024, the Repro Uncensored (RU) coalition was formed by Amnesty International, Plan C, Women on Web, Women First Digital, and Reproaction. RU combats digital censorship to ensure the free flow of abortion information online, and collaborates with various advocacy groups and experts to ensure : 1) transparent content moderation and advertising policies, 2) removal of abortion mis/disinformation, 3) protection of information rights and privacy online.

Repro Uncensored focuses on advocacy, education, and research. It campaigns globally to end digital suppression of abortion information. It raises awareness through workshops, panel events, and partnerships with global organizations. Furthermore, it also collects and analyzes instances of censorship, offering a resource hub for researchers to understand digital suppression of sexual health and reproductive content.

RU, along with its 23 member organizations and 6 creative partners, has created a space for global action to combat digital suppression and address the harmful impact of content moderation on abortion access and reproductive rights. They advocate for policy changes, develop strategies to counter digital suppression, hold discussions with Big Tech, engage with media, and restore access to censored content through their network.

Abortion rights advocates lead this effort, but it requires a multifaceted approach. Social media users can share tips on identifying misinformation, and medical professionals can provide accurate abortion information online. Collaboration between digital rights and abortion rights activists strengthens initiatives because addressing digital suppression of abortion information is a shared responsibility.

FC03

Contraceptive use and subsequent pregnancies 12 months following post-abortion placement of intrauterine devices: Secondary outcomes from a randomized controlled trial of placement within 48 hours vs. interval placement at 2-4 weeks after complete abortion.

PhD Sara Hogmark[1], PhD Niklas Envall[1], Professor Kristina Gemzell Danielsson[2], PhD Helena Kopp-Kallner[1]

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Abstract

Background: Intrauterine devices (IUDs) effectively prevent unwanted pregnancies. Little is known about long-term outcomes of women choosing an IUD after early medical abortion.

Objectives: To assess choice of IUD type and other contraceptives after abortion, contraceptive continuation and factors associated with continuation and discontinuation, satisfaction with IUD, IUD expulsions, subsequent pregnancies, and abortions within 1 year post-abortion.

Method: Randomized, controlled, multicenter trial on IUD placement within 48 hours compared with placement 2-4 weeks after medical abortion up to 63 days' gestation. IUDs were provided free of charge, which was not common clinical practice.

Results: Among 240 women studied, 12 months follow-up was completed by 112/120 (93.3%) in the intervention group vs 113/120 (94.2%) in the control group. IUD use at 12 months was 84/112 (75%) and 75/113 (66.4%) in the intervention and control group, respectively (p=0.19). Attending the IUD placement visit was the only predictor continued IUD use (relative risk [RR] = 5.7, 95% confidence interval [CI] 2.03-16.0). High contraceptive effectiveness was the main reason for opting for an IUD. Bleeding problems and abdominal pain were common reasons for discontinuation. IUD expulsion was rare and did not differ between groups. Satisfaction among IUD users at 1 year was high (>94%). Use of no contraception was 11/112 [9.8%] vs 25/113 [22.1%] in the intervention and control group, respectively (p=0.02). There was no difference in the rate of subsequent pregnancies and abortions.

Conclusions: IUD placement within 48 hours or interval placement at 2-4 weeks after early medical abortion led to high continuation and satisfaction rates with no differences between study groups. Neither did expulsion differ between the groups. Immediate placement within 48 hours and provision of IUDs free of charge at the abortion clinic merits implementation as it likely increases attendance to the placement visit and continued use of IUDs after abortion.

FC04

Effectiveness of a 24-hour compared to a 48-hour interval between mifepristone and misoprostol in abortion at 9 to 20 gestational weeks: an international randomized controlled non-inferiority trial

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Abstract

Background

Optimizing second-trimester medical abortion is important as complications increase with gestational age. We aimed to compare 24-hour (h) and 48h mifepristone-to-misoprostol intervals for medical abortion for effectiveness and acceptability.

Methods

This was a randomized controlled non-inferiority trial at nine clinics in India, Sweden, Thailand, and Vietnam among adults undergoing medical abortion for a singleton viable pregnancy between 9- and 20 weeks gestation (GW). Allocation was 1:1 to receive 200 mg mifepristone orally, then admission and 800ug misoprostol vaginally either 24h or 48h later followed by 400µg misoprostol sublingually 3-hourly. If no abortion occurred after five doses, mifepristone 200mg was repeated, followed by the same misoprostol regimen the following day. Our main outcome was successful abortion defined as fetal expulsion within 12h of initial misoprostol dose. Our non-inferiority margin was 5%. Outcomes were compared by modified intention to treat (mITT) where discontinuations before the intervention were excluded.

Findings

Between February 2015 and October 2016, we randomized 540 women of which nine discontinued before the abortion. By mITT, success rate in the 24h and 48h groups were 236/266, 88·7%, versus 248/265, 93·6% (OR 0·54, 95% CI 0·29-1·00). The risk difference was 4·9% (95% CI 0·05%- 9·7%). Success rate at 24h and rates of incomplete abortion were similar across groups. In the 48h group median misoprostol dose and induction time were lower, and more women found the abortion shorter than expected.

Interpretation

A 24h mifepristone to misoprostol interval has a similar success rate to 48h but cannot be defined as non-inferior.

FC05

Long-term impact of unintended pregnancies carried to term on mothers and children

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Abstract

Background. Research on psychological effects of unintended pregnancies that are carried to term presents mixed results, and evidence on long-term associations is scarce.

Objectives. The aim of the current study was to examine effects of unintended pregnancies carried to term on both mothers and children, up to 16 years postpartum.

Methods. This study is based on the Dutch population-based birth cohort study 'Amsterdam Born Children and their Development' (ABCD-study), which included pregnant people in 2003 (n = 7784) and is still following these mothers and their children. Structural Equation Models were analyzed per time-point, examining associations between unintended pregnancy and maternal psychosocial distress, and children's internalizing- and externalizing problems, while controlling for co-occurring risks. Further, mediating effects via maternal mental health and bonding on children were assessed.

Results. Around 5 years postpartum, pregnancy mistiming was positively associated to maternal psychological distress. Antenatal psychological distress was a much stronger predictor of maternal psychological distress than unintended pregnancy. Pregnancy mistiming was a significant predictor of internalizing and externalizing problems and unwanted pregnancy of internalizing problems in the children from these pregnancies, around 5 years postpartum. These associations were mostly mediated by maternal mental health and poorer maternal bonding. All associations were no longer present at 12 and 16 years postpartum.

Conclusions. Unintended pregnancies often coincide with maternal mental health problems, and results showed that associations between unintended pregnancy and both mother's and children's psychosocial problems are strongly influenced by maternal mental health. Therefore it is important to improve maternal mental health for the benefit of both mother and child, rather than on the isolated effect of unintended pregnancy.

FC06

Evaluating clinician vs. non-clinician screening models for no-test medical abortion: impact on ultrasound use, safety and waiting-time-to-treatment

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Abstract

Background
In no-test medical abortion (NTMA), patients only have an ultrasound when their last menstrual period is uncertain or they have ectopic pregnancy risk factors. Whilst studies suggest some important indicators, there is no consensus on optimal ultrasound screening questions or service delivery models. Since April 2020, British Pregnancy Advisory Service (BPAS) has offered NTMA up to 10 weeks' gestation. As the service evolved, we adapted our ultrasound screening model.

Objectives
We assessed the operational and safety impact of three phases of screening models to determine need for pre-abortion ultrasound.

Methods
We compared three phases of BPAS screening models:

1. Clinician assessment via teleconsultation (05/2021–01/2022)
2. Non-clinician assessment/self-reporting in online medical history questionnaire (MHQ) at booking (08/2022–04/2023)
3. Revised non-clinician assessment/self-reporting online MHQ at booking (06–08/2023)

Between phases, we compared proportions of patients requiring a pre-abortion ultrasound up to 10 weeks' and median waiting-time-from-contact-to-medical-abortion. We compared the proportion of ectopic pregnancies and cases of misestimation of gestational age identified post-NTMA.

Results
Across all phases, 145,682 patients had an abortion up to 10 weeks' at BPAS. In phase 1, 36.1%(19,771/56,501) had an ultrasound, compared to 53.4% (35,643/69,741) in phase 2, and 45.7% (8,431/19,440) in phase 3. Compared to phase 1, patients in phase 2 were twice as likely to have an ultrasound (OR: 2.03,95% CI:1.98-2.08). This reduced to 1.48 times in period 3 (95% CI OR:1.44-1.54).

Amongst medical abortion patients, median waiting time in period 1 was 10 days(IQR:6-14) vs 8 days for P2(IQR:3-11) and P3(IQR:4-10).

Neither proportions of ectopic pregnancies identified post-NTMA (P1:0.07%,P2:0.10%, P3:0.10%;p=0.3) nor of cases of misestimation (P1:0.06%,P2:0.04%,P3: 0.04%; p=0.3) differed across models.

Conclusions
Clinician NTMA ultrasound assessment resulted in the fewest scans, but elongated waiting times. Unidentified ectopic pregnancy and gestational age misestimation remained low across all models.

FC07

Origin of “Conscientious Objection” in Health Care: How Care Denials Became Enshrined into Law Because of Abortion

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Abstract

The United Kingdom was the first country to legalize the refusal to provide health care in the name of “conscientious objection”, allowing doctors to refuse to provide abortions based on personal or religious beliefs. This practice is renamed "belief-based care denial" because the term “conscientious objection” is inaccurate when applied to healthcare and it cannot be compared to military conscientious objection.

A historical review into the origins and motivation behind the “conscientious objection” clause in the UK's 1967 *Abortion Act* shows that the introduction of belief-based-care denial in health care was rooted in fears and misapprehensions, and abortion stigma. Parliamentarians and the medical profession wanted to preserve doctors’ authority over patients, protect objecting doctors from liability, and appease religious anti-abortion beliefs.

Belief-based care denial has since spread around the world, and evidence shows that the practice has caused many harms and injustices to patients and their access to reproductive health care. Further, belief-based care denial is not supported as a right by international human rights bodies, who recognize the problems and call for limits in its exercise. Since care denials are mostly limited to reproductive healthcare, primarily abortion and contraception services, they can be viewed as sex-based discrimination against women and gender minorities.

The UK and other countries should disallow and phase out the practice of belief-based care denial using disincentives and other measures to encourage objectors to choose other fields. The experience of Sweden and Finland proves this is not only possible but is the best way to safeguard the health and lives of women and others seeking abortion care.

FC08

Whether a shout or a whisper: Abortion storytelling as a catalyst for social change in Germany, Sweden, and the United States

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Abstract

Background: Storytelling expands understanding of important experiences for both abortion seekers and abortion providers in national and international contexts. By fostering empathy, moral development, and a nuanced understanding of justice and human experience, abortion storytelling can serve as a catalyst for social change.

Objectives: This project examined abortion stories from three countries: 1) Germany, through biographic-narrative interviews with people who had abortions; 2) Sweden, via Julia Hansen's autobiographical graphic novels *Two Lines = Pregnant* and *Det Växer*, about her two abortions; and 3) The U.S., where the social media hashtag #ShoutYourAbortion became an international call to action and transformed the abortion storytelling landscape.

Method: This project's collaborators represent the diverse fields of academia, activism, and abortion care. The reproductive justice framework inspired the analysis of participant interviews, abortion seeker and abortion provider stories, and the graphic novel. Narrative analysis and grounded theory guided the fine analysis of key points and comparison of the different storytelling approaches.

Results: Abortion storytelling blends art, activism, and awareness-raising to help laypeople, activists, and academics understand the nuances of abortion experiences and their role in catalyzing social change. Interviews with people who had abortions indicated that storytelling impacted their understanding of the abortion process, emotions, and interpersonal relationships. Qualitative interviews themselves are a form of abortion storytelling, enabling a contextual understanding and exploration from a social scientific perspective. People who shared abortion stories felt like they contributed to destigmatization efforts and those who accessed others' stories reported more empathy about abortion as a human right.

Conclusions: Abortion storytelling takes many forms and serves a variety of purposes, especially in diverse settings like Germany, Sweden, and the U.S., where abortion laws and provision vary greatly. Future research should examine the international reach of popular abortion storytelling and evaluate culturally-appropriate applications for social change.

FC09

General Practitioner Experiences of Implementing Community Medical Abortion Model in Ireland

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Abstract

Background

The Irish model of abortion care is distinctive for being located in the community comprising medical abortion provision by General Practitioners (GPs). Characterised as a community medical abortion model by the WHO, the design, implementation, and provision of abortion services for the first time in Ireland following legal change in 2018 is unique internationally. GPs were central to the design and implementation of this service.

Objectives

This paper reflects on the experience of Irish GPs providing early medical abortion (EMA) in the community five years on from initiation of the service, on the evolution of an infrastructure of peer education and support, and the engagement of stakeholders at policy and service planning levels.

Method

A committed group of providing GPs formed a research group to capture a collaborative account of peer organising, training and support they have created and been involved in since the implementation of the service. A qualitative experiential narrative account of this process has been collaboratively generated by the group using shared online documents. Service users' experiences of GP provision has been captured by academic and policy research and synthesised to supplement GPs collaborative narrative.

Results

An infrastructure has been developed by EMA providing GPs for training, peer support and critical reflective practice. This paper charts that process of providing GPs organising together, and considers what infrastructure a community medical abortion model needs to be to ensure its quality, safety and accessibility. It further considers the evolution of community provider policy/service planning engagement and asks if this meets needs identified for sustainability.

Conclusions

Committed GPs providing a community model of medical abortion evolved an infrastructure of training, peer support and reflective practice. Sustainability of the service requires partnership and support from policy and service planning actors responsive to insights from evolving knowledge, understanding and practice.

FC10

The behavioral health repercussions of accessing abortions in a post-Roe world: a cross-sectional study

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Abstract

Background

Since the Dobbs v. Jackson decision, 15 states have instituted total abortion bans. Individuals in abortion-restrictive states must travel for abortion services, imposing financial burdens, care delays, and detrimental impact on mental health.

Objectives

To evaluate associations between travel for abortion and behavioral health repercussions.

Methods

We conducted a cross-sectional survey from July 2023-April 2024 querying demographic characteristics, reproductive history, and stress and anxiety scores through online HIPAA-compliant data collection. The questionnaire was administered to reproductive-age individuals seeking abortions at three abortion centers in DC and Maryland.

Results

A total of completed 123 surveys were included in the analysis (of 171 total responses). Overall, respondents identified as Black (74%), single (83%), had at least a high school education (93%), and earned less than $50,000 income (64.8%). 83 were considered in-state (travel time <60 minutes) and 40 out-of-state (travel time >60 minutes). Compared to in-state, out-of-state participants were more likely to identify as White (25 vs. 8%), cohabiting (60.9 vs. 32.7%), married (20 vs. 3.6%). Out-of-state participants were more likely to fear travel across state lines (7.5 vs 0%), worry about the law/police, (15 vs 0%), and to worry about possible treatment afterward (7.5 vs 0%). On a Likert scale from 1-4, out-of-state participants found it more difficult to find a place to obtain care (2.28 vs 1.57), schedule an appointment (1.93 vs 1.46), and find money to terminate the pregnancy (2.58 vs 1.94) (P<0.001).

Conclusions

This study demonstrates that those forced to travel for abortion care report more stress surrounding traveling and obtaining funds. A greater proportion of those traveling have a higher annual income and identify as White, raising concerns regarding health equity and the pregnancy repercussions are for those who cannot afford to travel for an out-of-state abortion.

FC11

Examining Progress and Obstacles in Enhancing Safe Abortion Services in Nepal: An Analytical Assessment of Evidence from 2002 to 2022

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Abstract

Background: The provision of comprehensive safe abortion services is a key priority for Nepal's Ministry of Health and Population (MOHP) since the legalization of abortion in 2002. Despite significant progress made by the government in ensuring access to safe and legal abortion services, challenges persist for individuals seeking these services.

Objectives: We assessed the achievements made in the provision of safe abortion services in the past two decades, current barriers and challenges, and what needs to be done to overcome these in Nepal.

Methods: An extensive review of published and gray literature between the period of 2002-2022 was carried out and analyzed based on major themes.

Results: We found that Nepal has made significant progress to ensure the right to safe abortion services. For example, the country's new Constitution of 2015 and the 2018 SMRHR Act guarantee the right to an abortion as a fundamental right for every woman. The MOHP has developed and updated regulations, strategies, and directives for implementing the abortion law, expanded training sites, and task shifting for medical abortion to expand the base of providers, Similarly, medical abortion was introduced in Nepal in 2009 and now expanded to all 77 districts of the country. However, significant challenges remain, including inconsistencies between legal provisions, lack of provincial or local level directives for abortion provision, limited awareness of available services, stigma, and cost barriers. Moreover, there are shortages of trained providers and facilities, and issues with the effective implementation of free abortion services policies.

Conclusions: Overcoming these challenges requires strategic policy and programmatic interventions to ensure access to legal and safe abortion services for all in Nepal. Addressing these issues is crucial for upholding the fundamental right to abortion care and improving reproductive health outcomes in the country.

FC12

Safety and accuracy of dating unwanted pregnancies and detecting ectopic pregnancy without using ultrasonography

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Abstract

BACKGROUND

Evidence suggests that pre-abortion ultrasonography is unnecessary for healthy women with regular menstrual cycles and no symptoms or risk factors for ectopic pregnancy in early gestation.

OBJECTIVES

The study sought to evaluate the safety and accuracy of using the flowchart developed by the RCOG COVID-19 Infection and Abortion Care group on the necessity of pre-abortion ultrasonography.

METHOD

Using gestational age expected by last menstrual period (LMP) and self-reported symptoms indicative of possible ectopic pregnancy, women were classified into "no ultrasound needed" and "ultrasound needed". Findings on ultrasonography were then evaluated to assess classification accuracy.

RESULTS

Between September and December 2023, charts of 494 women attending the abortion clinic at the Helsinki University Central Hospital were reviewed. Correct classification would have been made in 492/494 (99.6%) cases. The remaining two cases (0.4%) were ectopic pregnancies without symptoms that would have been referred to the "no ultrasound" group based on interview.

The majority, 400 women (81%), met criteria for no ultrasound based on LMP. In this group, no ectopic pregnancies were detected, and only three women had an unexpected gestational age exceeding 10+0 (10+1-3).

Altogether, 92 women (18.6%) would have been scheduled for ultrasonography based on LMP or patient characteristics. In this group, we detected three symptomatic ectopic pregnancies (3.2%). The most common reason for need of US based dating of the pregnancy was an unclear LMP or LMP beyond 10 weeks (81 women, 88%). The rest were women who were currently using hormonal contraception (8; 8.6%).

CONCLUSIONS

Using the structured flowchart developed by the RCOG prompts accurate evaluation of which women needing ultrasonography. The two ectopic pregnancies without symptoms would have gone

unnoticed, highlighting the importance of informing women about possible ectopic pregnancy symptoms during abortion procedures, similar to practices in wanted pregnancies not routinely dated before late first trimester.

FC13

Inspiring the next generation of abortion care providers and future abortion champions

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Abstract

Background

In 2012 the Royal College of Obstetricians and Gynaecologists (RCOG) released a statement outlining their concerns about the future UK abortion workforce. Junior doctors, they claimed, no longer wanted to work in abortion care, which would ultimately lead to a crisis in provision in the following decades.

Objectives

To analyse a range of activities, motivated by this statement, designed to inspire the next generation of UK abortion providers and future abortion champions.

Method

The following activities were analysed:

1. The design and delivery of comprehensive and inclusive core medical school teaching on abortion.
2. The development of medical school abortion-related voluntary courses and extra-curricular activities.
3. A national Curriculum Champions project that worked with stakeholders to improve medical education on abortion throughout the UK.
4. The implementation of Doctors for Choice UK (DfCUK) strategy to recruit younger members.

Results

96% of students rated the improved abortion teaching as ‘important’, regardless of their attitude to abortion. Drawing on the comprehensive and inclusive teaching resources, the Curriculum Champions project has improved medical school teaching on abortion in at least 16 UK medical schools.

Student membership of Doctors for Choice UK went from 0 to 76 following the implementation of its strategy to recruit younger members. 50% of the current DfCUK committee and 10% of Community

Sexual and Reproductive Health trainees attended the medical school with the most comprehensive abortion teaching and widest range of abortion-related extra-curricular activities.

Conclusion

In order to inspire the next generation of abortion care providers it is essential to deliver comprehensive medical school abortion education. Giving medical students access to abortion-related voluntary courses and extra-curricular activities, and involving them in abortion advocacy, helps inspire future abortion champions.

FC14

Out of control! – how self-managed abortion and feminist organizing are challenging power structures

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Abstract

Self-managed abortion (SMA) is a revolutionary practice where individuals independently source and utilize abortion pills, bypassing hegemonic medical systems. Originating in the 1980s within the Global South as an experimental approach, SMA has since burgeoned into a global phenomenon, profoundly altering the landscape of abortion care. For several decades, feminist networks have actively engaged in direct action to support individuals choosing SMA, underscoring the practice's significance in the broader struggle for reproductive autonomy.

SMA embodies both self-care and collective care practices, posing a formidable challenge to oppressive systems that seek to exert control over individuals' bodies. This session will feature reflections from activists associated with pivotal organizations such as Women Help Women, Abortion Without Borders, and Abortion Dream Team. These activists will elucidate the key features of SMA and the feminist organizing efforts that confront and diverge from mainstream abortion movements, as well as the entrenched power structures intent on disciplining bodies.

Through these reflections, the session will highlight how SMA and feminist activism disrupt mainstream narratives and challenge power structures, advocating for a more autonomous, equitable, and accessible approach to abortion care. By opposing centralization, stringent legal restrictions, the medicalization of abortion, hegemonic scientific paradigms, and profit-driven healthcare markets, these activists promote a vision of abortion care rooted in empowerment and social justice.

The discussion will delve into the historical evolution of SMA, its current practices, and the ongoing feminist organizing that sustains it. Attendees will gain insights into how SMA operates as a form of resistance, offering a decentralized, community-driven model of care that prioritizes the agency and well-being of individuals. This session aims to broaden the understanding of SMA's impact and inspire further dialogue and action towards achieving a more just and liberated approach to abortion care.

FC15

#IamJustyna – the pan-European and global mobilization to protect providers and supporters of self-managed from criminalization.

Justyna Wydrzynska[1,2,3], Kinga Jelinska[4,5,6], Natalia Broniarczyk[7,8]

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Abstract

The defense of all abortion providers, including those who support self-managed abortion, is critical to abortion access.

Justyna Wydrzyńska from Poland has been an abortion doula since 2006, founded the Polish hotline and the Women on the Net forum, and co-founded the Abortion Dream Team. The Abortion Dream Team is also part of Abortion Without Borders, a European feminist network that provides information, funding and practical support to people in Poland who need an abortion abroad, or access to reliable online sources to obtain abortion medicines through Women Help Women. Abortion Without Borders has supported safe abortions for over 78 000 people from Poland in the last 2 years, while the Polish state provided only 161 abortions in all of 2022. The activist network is the main provider of abortion care for the whole country.

Justyna was convicted in a criminal case for helping another woman to have an abortion and awais appeal. The success of mobilizing global support for her case is an important lesson for our movement.

The objective of the session is to share strategies of defense for providers of self-managed abortion, as well as provoke self-reflection and action from our movement in relation to the incompatibility of local legal regimes on medical abortion provision with the recommendations based on public health evidence and human rights standards. This story happened in Poland, but is a cautionary tale for all of us, as abortion pills remain over-regulated and medicalized worldwide, and competent providers like Justyna risk criminalization everywhere, including in countries with so called liberal laws. Session attendees will learn about threats to all providers when anyone is criminalized, the need for demedicalization and deregulation of abortion pills within the EU and globally, and innovative community-based efforts to help people with unwanted pregnancies in Poland and throughout Europe.

FC16

The Story of a Small NGO meeting Colossal Needs

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Abstract

Background

In Malta, abortion is illegal, except in high risk of death.The non-governmental organisation (NGO), Doctors for Choice Malta (DFCM) was established in 2019, to advocate for decriminalisation of abortion, better access to contraception and comprehensive sex education.

During the Covid-19 pandemic, Malta saw a shift from the traditional practice of women travelling to access abortions, to having illegal medical abortions (500 in 2023), without medical supervision. Therefore, DFCM, together with two other NGOs, set up the Family Planning Advisory Service (FPAS) for callers to access information about reproductive health issues by using the Wix app chat function. Those requiring medical advice are transferred to the DFCM-run Abortion Doula Service Helpline for support over the phone before, during and after abortion.

Objectives

To identify people's perceived needs for information on reproductive health

To measure the impact of the DFCM and FPAS websites on how people in Malta access abortion

To measure the worldwide reach of the DFCM and FPAS websites

Methods

Performance statistics on Google Search Console and statistics of users contacting FPAS on the Wix app were analysed.

Results

Between 1st April 2023 and 31st March 2024, the DFCM and FPAS webpages garnered 102k and 52.4K clicks, and 1.39m and 1.95m impressions, respectively. The DCFM page is most popular in the US (25,861 clicks), while the FPAS page is most accessed in Ukraine (21,034 clicks). The FPAS page received 2834 callers through the Wix chat function since 2020, while the Abortion Doula Service has at least one call a day. The most popular DFCM webpage discusses what happens if one vomits after taking abortion pills (33,946 clicks; 148,278 impressions.)

Conclusion

Through the provision of reliable information, a small NGO with limited resources has supported thousands worldwide with their reproductive health.

FC17

What do Maltese doctors think about abortion?

Professor Isabel Stabile[1], Dr Andrea Dibben[1], Dr. Natalie Psaila Stabile[1], Dr Ian Psaila[2], Dr Jamie Grech[2]

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Abstract

Background

Malta, with a population of half a million is the smallest and southernmost EU state. In spite of an almost complete ban on abortion, approximately 500 women underwent a medical abortion in 2023. The current legislation criminalises both the woman and whoever assists her in the abortion. There are no exceptions for cases such as fatal fetal abnormalities, rape or incest.

Objectives

To explore the knowledge and beliefs of medical doctors with regards to abortion

Method

An online survey was distributed via email to all hospital doctors and specialists in family medicine. Participants' responses on knowledge and personal beliefs about abortion were analysed.

Results

173 doctors responded to the questionnaire, of whom 59.5% were female, 96.6% Maltese, 25.4% single, 61.8% Catholic, 64.2% graduated after 2014, and 31.2% stated that religion was important in their lives.

57.2% incorrectly believed that those accessing abortion services abroad can be criminally prosecuted in Malta, 38.2% incorrectly stated that providing information about abortion is illegal, and a further 28.9% believed that legalising abortion will increase the number of women seeking abortion. The mode for the Knowledge Score was 6 out of 10 (32% of participants).

71.1% agreed that women should not be punished for having an abortion, while another 68.8% think that healthcare professionals should not be penalised for helping them. A further 66.5% agreed that a total abortion ban leads to potentially unsafe abortion practices, 52% stated that is possible to be personally opposed to abortion and be pro-choice, and 22.5% agreed that abortion is like taking a life because life begins at conception.

Conclusion

Although the majority of Maltese doctors agree that abortion should be decriminalised for both women and doctors, and that the current ban is unsafe, most are still severely lacking in their knowledge about abortion.

FC18

Advance Provision of Abortion Pills in Poland

Dr Hazal Atay[1], Dr Suzanne Veldhuis[2,3], Marcela Trocha[2], Weronika Majek[2], Associate Professor Jennifer Fishman[4]

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Abstract

Background

In high-income countries, the availability of legal medical abortion has shifted the timing of abortions to occur earlier in pregnancy. In 2022, Women on Web introduced the advanced provision of abortion pills to Poland, a highly restrictive country. Advanced provision involves providing abortion pills to individuals before they are pregnant, allowing them to access abortion care promptly when the need arises. In legally restricted settings such as Poland, access to abortion is limited in the first trimester and remains extremely restricted beyond 12 weeks. In initiating this service, Women on Web contends that providing access to abortion pills before they are needed may help individuals overcome local restrictions to abortion care and enable them to access abortions earlier in their pregnancy.

Objective

This study aims to explore advanced provision of abortion pills in Poland by Women on Web.

Methods

This exploratory study describes the advanced provision requests from Poland between 2022 and 2023, examining the demographics and motivations of care seekers, their evaluations of the service, and their trajectories of use.

Results

Our analysis reveals that while most individuals who completed an online consultation for advanced provision were not pregnant at the time of care seeking (81.4%), some thought or suspected being pregnant at the time of care seeking (18.6%). The main drivers to advanced provision include legal restrictions (68.7%), the unavailability of abortion pills (55.1%), and the individuals' preference to have an abortion at the comfort of their home (47%). While most care seekers evaluated the service rather positively, emphasizing their satisfaction, the trajectories of use varied. While some declared having ordered pills just in case and not having used them (yet), others declared having used them and shared their medical abortion experiences.

Conclusion

Advanced provision is an innovative approach to abortion care which allows for timely access to abortion pills, especially in restrictive settings.

FC19

The impact of intimate partner violence on post-abortion mental health: observations from an abortion accompaniment service

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Abstract

Background

The Centre Jove D'Atenció a Les Sexualitats (CJAS) is a sexual and reproductive health center located in Barcelona, Spain. CJAS offers free medical care (i.e. abortion, contraception, gynecologic care) and counselling services for users. An abortion accompaniment service was started in 2022.

Objectives

We aim to describe our model of post-abortion accompaniment, share lessons learned from our practical experience, and identify potential areas for future research in abortion accompaniment.

Methods

Users can schedule an appointment through referrals from any abortion clinic, through CJAS, or through the social media, mail, or abortion hotline of the CJAS "Vull Avortar" program. Accompaniment was offered to 63 users in 2023, of which 20 ultimately utilized the service. These 20 users had a total of 43 visits (3-4 visits per person on average). Users can attend a maximum of 10-12 visits.

Results

Through our practical experience in post-abortion accompaniment, we have observed that in a number of cases, sexism and intimate partner violence (IPV) contribute to one's mental health post-abortion. While historically the scientific literature has surmised that one's emotional well-being is negatively impacted by the act of having an abortion itself, our practical experience suggests that having an abortion may expose existing mental health issues related to sexism and IPV. Given that reproductive coercion can be related to the experience of becoming pregnant (i.e. contraception negotiation, pressure to engage in sexual activity) or the decision to have an abortion, the emotional impacts and mental health problems following an abortion may be related to these underlying issues rather the abortion itself.

Conclusions

The impact of sexism, patriarchy, and IPV must be evaluated by all entities practicing post-abortion accompaniment. Further investigation regarding the compounding effects of sexism and IPV should be conducted to increase our understanding of mental health needs following an abortion.

FC20

Barriers preventing gynecologists from performing abortions in Germany

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Abstract

Background

Around 95% of all abortions in Germany take place during the first 12 weeks after mandatory counseling and 3 days mandatory waiting time. These abortions are considered unlawful, but they remain exempt from punishment (§ 218a German Penal Code). Due to this unlawfulness, abortion care is currently not ensured through regular planning instruments of health care. Therefore, in Germany there are significant regional differences in accessibility and availability of abortion providers. As a result, women have to put up with long distances and long waiting times in less supplied areas.

Objectives

In order to find explanations for regional differences in abortion care, the ELSA study examined barriers preventing doctors from performing abortions and their regional distribution. In addition, the findings should explore potential for measures to improve regional access to abortion care.

Method

A standardized online survey of all gynecologists in three regions (federal states of Bremen and Mecklenburg-Western Pomerania and administrative district Tübingen) was carried out. The regions differ in terms of availability and accessibility of abortion providers as well as in terms of socio-demographic characteristics. The data were evaluated using descriptive statistical methods.

Results

678 gynecologists (response rate 62%) were reached. The respondents name both internal and external barriers to performing abortions. The data show regional differences in the prevalence of internal and external barriers. The most frequently mentioned barriers are: abortions are not performed in their work place (34%), the procedure is experienced as stressful (34%), there are no suitable rooms available (33%). Only 6% gave the reason that they generally reject abortions. Many respondents would be willing to perform abortions, especially if external barriers were removed.

Conclusions

Even in regions where internal barriers are more prevalent, many gynaecologists would be willing to perform abortions under changed conditions.

FC21

Intrauterine device placement within 48 hours vs interval placement at 2-4 weeks after second trimester medical abortion: a randomized controlled trial

PhD Sara Hogmark[1], MD Johanna Rydelius[2], PhD Niklas Envall[1], PhD Pia Teleman[3], Professor Kristina Gemzell-Danielsson[4], PhD Helena Kopp-Kallner[1]

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Abstract

Background: International guidelines recommend placement of intrauterine devices (IUDs) immediately after second trimester medical abortion. Evidence on the optimal placement timing is lacking.

Objectives: Investigate effectiveness, safety, and acceptability of IUD placement within 48 hours compared to placement at 2-4 weeks after second trimester medical abortion. Primary outcome: group differences in proportion of IUD use at 6 months postabortion. Secondary outcomes included expulsion rates, pain at placement, adverse events and complications, acceptability, and subsequent pregnancies and abortions.

Method: Open-label, randomized, controlled, superiority trial in Sweden. Inclusion criteria: ≥18 years, requesting medical abortion with gestation ≥85 days, opting for a post-abortion intrauterine device. Participants were randomized (1:1) to intrauterine device placement either within 48 hours of complete abortion (intervention) or after 2-4 weeks (control). The IUDs were provided free of charge which is not the clinical practice in Sweden. Results are presented using modified intention-to-treat (MITT) and per protocol (PP) analyses.

Results: From January 2019 to June 2022, we randomized 179 participants (90 to intervention and 89 to control). Following an interim analysis which showed a higher expulsion rate than a predefined cut-off of 20%, enrollment was prematurely stopped. By MITT, IUD use at 6 months was 50.7% (34/67) and 71.6% (48/67) in the intervention and control groups, respectively (proportion difference 20.9%; 95% confidence interval 4.4%-35.9%; p=.02). The IUD expulsion rate whiten 6 months was 30.1% (22/73) in the intervention group versus 2.9% (2/70) in the control group (p<.001).

Conclusion: IUD placement within 48 hours after second trimester medical abortion was non-superior compared to placement at 2-4 weeks in terms of the proportion of IUD use after 6 months. However, placement within 48 hours can be used in selected individuals after counseling on expulsion risk.

Posters

After an abortion

P01

Associations between method of abortion and post-abortion contraception uptake: an analysis from Nepal, Cameroon and Ethiopia

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Abstract

Background

Post-abortion contraception is a critical element of comprehensive abortion care services and reduces rates of subsequent induced abortion and decreases maternal mortality.

Objectives

To examine the relationship between the type of abortion service provided (medical, surgical, treatment of incomplete abortion) and the type of contraceptive initiated after abortion (short-term acting methods, long-term acting methods) among women accessing abortion services through IPPF member associations in Cameroon, Ethiopia and Nepal.

Methods

Using abortion service statistics data (2015-2023) recorded in DHIS2 software, we conducted correlation and linear regression model analyses.

Results

Over nine years, the three countries provided 241,617 abortion services, with an overall post-abortion contraceptive uptake of 87.5%: 80% (Cameroon), 96% (Ethiopia), and 76% (Nepal). We found significant positive correlations between post-abortion contraception and second-trimester surgical abortions (PCC = 0.9) and treatment of incomplete abortion (PCC = 0.82).

Linear regression demonstrated that the likelihood of uptake of a long-acting contraceptive was increased following surgical abortion by 0.03% per service ($p < 0.01$), which was about three-fold their uptake following a medical abortion (0.01%). Short-acting contraceptives were also more likely to be initiated following surgical abortion by 0.01% ($p<0.001$), than following medical or treatment of incomplete abortion.

Conclusions

Our analysis indicates that surgical abortions are associated with higher uptake of post-abortion contraception, both long and short-acting, based on service-level data. As a procedural abortion can facilitate the immediate placement of a long-acting contraceptive, it may be part of a client's consideration when choosing their abortion method. Therefore, information about contraceptive options should be included in comprehensive abortion services to better meet the needs of clients.

P02

The role of a peer contact in abortion aftercare

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Abstract

Research results state that peer support interventions may be effective for the recovery of mental illness. Effects are modest, but significant and suggest potential efficacy (Smit et al., 2022)[1]. Analysis shows that support from peers is effective for learning to deal with the condition (personal recovery), with themes such as hope and more grip on life and contributes to the reduction of mental complaints (clinical recovery) and the growth of more hope, connection and social support (social recovery). .

In particular, research points to the crucial role of social support in coping with an abortion (Verschraegen, 2022)[2] in addition to formal and informal sources of support. The goal of this qualitative study is to explore what role peer support has for women who had an abortion and how this support influences their experience and abortion stigma. 15 interviews are analyzed by themes. Peers can provide support from their own experience. A unique force that ensures that women dare to share their experience, can talk openly without judgement, come out of their isolation and make their invisible loss visible. Fara vzw, which facilitates contacts with peers, is of great support. To the outside world, contact with peers plays a minimal role in breaking abortion stigma, but in the safety of contact, women can share their abortion experience without stigma. These results can contribute to greater awareness about the importance of peer contacts in contribution to recovery in addition to other treatments and policy.

[1] Smit, D., Miguel, C., Vrijsen, N.J., Groeneweg, B., Spijker, J. & Cuijpers, P. (2022, September 6), *The effectiveness of peer support for individuals with mental illness: systematic review and meta-analysis,* published online by Cambridge University Press.

[2] Verschraegen, K., *De rol van een lotgenotencontact bij het verwerken van een abortuservaring*. Masterproef Sociologie academiejaar 2021-2022. UGent, 2022. *https://lib.ugent.be/catalogi/rug01:003119292*

P03

Anxiety and depression following miscarriage: a prospective cohort study from Latvia

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Abstract

Background.Miscarriage is a common adverse reproductive outcome, occurring in 10-15% of all diagnosed pregnancies. While internationally there has been a growing body of evidence on the detrimental effects of pregnancy loss on women's mental health, the prevalence and impact of psychological distress following miscarriage in the affected individuals in specific populations on a national level - such as women in Latvia -is often scarce.

Objectives.The aim of this study is to investigate the impact of miscarriage on women's mental health by analyzing the frequency and severity of depression and anxiety following miscarriage at Riga East Clinical University Hospital.

Methods.This is a longitudinal cohort study conducted at the Gynecology Clinic of Riga East Clinical University Hospital in Riga, Latvia. Women hospitalized with the diagnosis of miscarriage were recruited between July and December 2023 and provided with a questionnaire at the time of hospitalization and three months after the pregnancy loss. The survey was based on the Generalized Anxiety Disorder 7 (GAD-7) and the Patient Health Questionnaire 9 (PHQ-9).

Results.Fifty women were initially enrolled in the study, and 41 completed the questionnaire three months post-miscarriage. At the time of hospitalization, 78% exhibited anxiety, which persisted in 73% after three months, mostly at a mild level. Depression was observed in 80% of participants both at hospitalization and after three months, with a trend towards increasing moderate depression. Various factors, such as low education level (p=0.02), longer time to conception (p=0.006), use of IVF (p=0.034), a wanted pregnancy (p=0.034) were identified as statistically significant risk factors for higher rates of anxiety and depression.

Conclusions.This study demonstrates that pregnancy loss significantly impacts women's mental health, with most individuals experiencing various degrees of anxiety and depression following a miscarriage. This underscores the importance of providing comprehensive and timely care for women recovering from this adverse pregnancy outcome.

Conscientious Objection

P04

WHAT THE REAL IMPACT OF CONSCIENCE CLAUSE ON ABORTION IN ITALY?

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Abstract

In Italy, women can contact any doctor to sign the request for abortion, but it can only be carried out in public hospitals, even if some limited practices have been started in public clinics.

Since abortion became legal, the number of public gynecologists has fluctuated between 4,000 and 6,000, with the number of non-objectors ranging between 1,400 and 2,500. The latest available data, referring to 2021, speak of 4,400 gynecologists (two thirds women), 2,790 objectors (63.4%) and 1,610 non-objectors (36.6%).

Despite regional differences, abortions are practiced in all regions without significant differences in waiting times. The critical issues are linked to structural problems in the healthcare system, as well as in the organization of the service.

The figure shows for each region the number of gynecologists, objectors and non-objectors, and the number of abortions, which is fundamental for understanding the real impact of conscientious objection. The table reports the annual number of abortions per gynecologist which at a national level is 33, less than one per week.

An interesting data come from the four hospitals in Turin, since the percentage of non-objectors is higher where few abortions are performed, while in the biggest hospital gynecologist performing abortion are 33, out of 41 non-objectors, with an average of 11 shifts per year. A greater number of non-objectors would not improve the service

Despite ideological polemics, conscientious objection has a real minimal impact on abortion in Italy, practically close to zero, with a lot of clamors in the squares, but a forty-year history of political apathy in the palaces.

In conclusion, it is useful to remember that in Italy assisted reproduction (ART) has the same conscience clause, but for this reason it has never created problems, as it is not a public monopoly like abortion and can be done privately.

P05

Conscientious objection and abortion training in midwives in Catalonia

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Abstract

Although midwives cannot perform abortions and their ability to invoke conscientious objection (CO) in Spain is contested, they play an important role in abortion access in Catalonia by providing informational and emotional accompaniment.

The objective of this study was to understand the different factors that influence midwives' decision to accompany abortions and the abortion training that they receive to identify potential barriers to abortion care.

An online survey was distributed to midwives currently practicing in Catalonia. Midwives were asked about their experience providing abortion accompaniment, the gestational ages at which they had provided accompaniment, and if they had not participated in abortion care, they were asked to clarify the rationale (personal beliefs, lack of eligible patients, lack of training, social stigma, etc.).

The majority of respondents (92%) had accompanied abortions: 90% for abortions at less than <14 weeks gestation, and 64% for abortions between 14 and 22 weeks. The most common reason for not providing accompaniment was that their facility did not provide abortions, or that no patient had requested accompaniment. While no midwife identified as a conscientious objector, 31% supported the right to CO in public centers and 9% supported institutional CO in religious centers. Respondents received abortion training during midwifery specialization (70%), clinical practice (67%), continuing education (82%), and nursing school (20%). Training in informational accompaniment (83%) was more common than emotional accompaniment (72%). Fewer respondents felt prepared to provide accompaniment after 14 weeks.

In this sample of midwives, individual CO was not a barrier to accompanying abortions. Many respondents indicated that abortions, especially after 14 weeks, were not provided in their facility. Therefore, reasons for which institutions do not provide abortions should be investigated, and training in emotional and informational support for abortions after 14 weeks should be provided to address barriers to abortion in Catalonia.

P06

Belief-Based Care Denial – Changing the terms of the debate

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Abstract

The term “conscientious objection” (“CO”) is incorrect and inappropriate when used to describe healthcare professionals refusing to provide care due to their personal or religious beliefs. The practice of “CO” is not conscientious and the term carries the assumption that abortion is morally wrong, making it a dishonest anti-choice term.

The new term “belief-based care denial” is already beginning to replace “CO.” In Canada, the term has taken hold across advocacy communities and is starting to appear in the academic literature. Belief-based care denial describes what is actually happening – the refusal to provide healthcare for reasons that are non-medical and ideological – which implies an illegitimate basis for such refusals.

The term “CO” was co-opted from military CO but has nothing in common with it. Unlike soldiers, doctors choose their profession and are in a privileged position. When “CO” was first legally allowed in healthcare under the UK’s 1967 Abortion Act, a primary motivation was moral disapproval of abortion by legislators, doctors, and medical societies. But abortion provision is an ethical act and a critical part of reproductive healthcare.

Belief-based care denial violates medical ethics and fiduciary duty, absolves healthcare professionals while transferring burdens to patients, harms patients in many ways, reinforces abortion stigma, and is used as political tool by the anti-choice movement to expand refusals to other workers and causes.

We call on everyone – healthcare professionals, medical societies, healthcare institutions, researchers, advocates, NGOs, government agencies, and more – to universally adopt the term belief-based care denial, discontinue the use of “CO,” and advocate that the practice be phased out.

P07

Patients oppose and are harmed by belief-based denial of reproductive care

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Abstract

Although contraceptive and abortion care are medically necessary services, healthcare providers in Canada are permitted to refuse to provide care or referrals on the basis of their personal beliefs. This qualitative study explored Canadians' experiences with belief-based care denial (aka "conscientious objection") of contraception and abortion and the consequences of this refusal in Alberta, New Brunswick, and Ontario.

Methods: Semi-structured, in-depth interviews were conducted with individuals who had experienced refusal of contraception or abortion care from November 2022 to March 2023. Interviews included questions about the participants' demographic characteristics, reproductive health histories, experiences with denial of health care, and perspectives on how abortion services could be improved.

Results: Out of 30 participants, 20 reported being denied contraception, 9 reported being denied abortion care, and 1 reported being denied both. Participants reported being denied tubal ligation or vasectomy because of age or parity, while denial of abortion care was related to the provider's religious beliefs, the religious affiliation of the hospital/facility, and because of very low gestational age. After being denied care participants felt angry, scared, disappointed, and frustrated. Some expressed concern over not having reproductive autonomy and described healthcare as sexist. Participants consistently voiced their opposition to policies that allow providers to refuse reproductive health services on the basis of their beliefs.

Conclusion: The Canadian government has repeatedly supported the provision of a full range of respectful, timely, and accessible reproductive healthcare. However, allowing providers to deny care based on personal beliefs creates barriers to access. Policymakers and clinicians should consider reforming regulations in line with patient-centered outcomes that are informed by patient experiences, establishing avenues for patients to report violations of practice standards, and creating enforcement mechanisms to ensure that Canadians receive the comprehensive reproductive health services they need and deserve.

Contraception

P08

Effects of an online educational video on contraceptive knowledge, preference and uptake in rural and culturally and linguistically diverse young women: findings from the Extend-Prefer study

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Abstract

Background

Young Australian women from rural areas, and those from culturally and linguistically diverse (CALD) backgrounds, are more likely to have an unintended pregnancy than their urban and non-migrant counterparts. Contraceptive knowledge can influence contraceptive choices, however access to contraceptive information is challenging for women in these populations.

Objectives

To assess whether a co-designed online educational video increases contraceptive knowledge, preference for and uptake of long-acting reversible contraception (LARC) in young women from rural and CALD backgrounds.

Method

Young women from these populations were recruited using social media advertising. Participants completed a pre-video survey (S1), watched the video and completed a survey immediately after (S2), and another survey six months later (S3). Outcomes were analysed using McNemar tests and multivariate logistic regression.

Results

A total of 313 women (153 rural/remote and 160 CALD) watched the video and completed S1 and S2, and 56% (86 rural/remote and 91 CALD) completed S3.

At S1 only 14% of CALD women and 3% of rural and remote women rated their contraceptive knowledge as high. Knowledge improved significantly at S2 among rural (aOR 12.5, 95% CI 5.2-29.8) and CALD women (aOR 3.2, 95% CI 2.5-5.0). Reported likelihood of using a LARC method increased significantly at S2 among rural (aOR 2.1, 95% CI 1.5-2.9) and CALD women (aOR 3.8, 95% CI 2.6-5.6). At the six-month follow-up, there was a trend towards increased LARC use among rural women, but this was not statistically significant. Contraception methods used by CALD women varied more, but the use of LARC did not increase.

Conclusions

Knowledge of LARC methods amongst young women are limited. The educational video increased their self-reported contraceptive knowledge and likelihood of using a LARC immediately after viewing. Non-significant increases in uptake of LARC at follow-up highlights the need to address structural barriers to LARC access.

P09

Free-of-charge LARCs after termination of pregnancy in 2020-2021 in the Netherlands; identifying characteristics of financially vulnerable women.

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Abstract

Background: In the Netherlands 31.000 terminations of pregnancy (TOP) are performed yearly, one in three is recurring. A new governmental regulation to reduce repeat TOPs permits abortion clinics to offer free-of-charge long-acting-reversible-contraceptives (LARCs) to financially vulnerable women seeking contraception after TOP.

Objectives: The objective of the study was to identify the characteristics of women choosing LARCs after TOP.

Method: The study was performed in abortion clinic Vrouwen Medisch Centrum (VMC). After TOP, women were counseled on contraception. LARCs were offered free-of-charge to financially vulnerable women. The LARC was inserted either immediately after a surgical TOP or 4-6 weeks after a medical TOP. Data collected includes age, type of TOP, parity, repeat TOP, financial status, and type of LARC chosen.

Results: Of the 3494 women electing for a TOP in 2020-2021 at VMC, 918 women (26,3%) chose a LARC. These women were included in the study. Most women chose a copper IUD (50,3%), followed by the hormonal IUD (41,9%) and the ENG-implant (7,7%). Most LARCs were inserted after a surgical TOP (68,6%). One in three women had a repeat TOP (28%).

Of the total cohort, 107 women were deemed financially vulnerable (11,7%) and were given a LARC free-of-charge. These women chose the ENG-implant more often (14%). Most LARCs were inserted after surgical TOP (76,6%).In comparison, these women were less likely to show up at a follow-up appointment and more often had a previous TOP (43% versus 28% in the total cohort), emphasizing the need for a reliable form of contraception in this group.

Conclusions: Identifying the characteristics of financially vulnerable women has shown that they are more likely to have repeat TOP. This highlights the need to remove costs as a barrier to choosing a reliable form of contraception, such as a LARC, reducing their risk of future unplanned pregnancy.

P10

Mepivacaine instillation for pain reduction during intrauterine device placement in nulliparous individuals: a double-blinded randomized trial

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Abstract

Background: Fear of pain during intrauterine device (IUD) placement is a known barrier to its use, reducing the use of long-acting reversible contraception.

Objective: To evaluate whether intrauterine instillation of mepivacaine before IUD placement reduces pain more effectively than a placebo.

Study Design: This multicenter, double-blind, placebo-controlled trial included nulliparous individuals undergoing IUD placement with an LNG-IUD 52 mg. Participants received either 10 mL of 20 mg/mL mepivacaine or 0.9 mg/mL sodium chloride via a hydrosonography catheter 2 minutes before IUD placement. Pain was measured using a 100 mm Visual Analog Scale (VAS) at specified time points. The primary outcome was the difference in VAS pain scores during IUD placement. Secondary outcomes included VAS pain scores at instillation and 10 minutes post-placement, pain tolerability, and acceptability of the analgesia method.

Results: A total of 151 participants were enrolled, with 76 in the mepivacaine group and 75 in the placebo group. The mean VAS pain score during IUD placement was 13.3 mm lower in the mepivacaine group (95% CI 5.75-20.87; P<0.001), with means of 53.9 mm (SD 22.8) and 67.2 mm (SD 22.4) for the mepivacaine and placebo groups, respectively. After adjusting for provider impact, the difference remained statistically significant (12.2 mm, 95% CI 4.85-19.62; P<0.001). More participants in the intervention group reported tolerable pain (70/75, 93.3%) compared to the placebo group (53/66, 80.3%) (P=.021).

Conclusion: Intrauterine instillation of mepivacaine significantly reduces pain scores in nulliparous individuals during IUD placement. Although the precise clinical impact of the pain reduction is uncertain, the instillation of mepivacaine leads to more participants reporting tolerable pain. These findings suggest that the intrauterine instillation of mepivacaine could be clinically relevant and may enhance IUD utilization among nulliparous individuals.

P11

BARRIERS TO PROMOTION AND UPTAKE OF VASECTOMY AS A METHOD OF CONTRACEPTION IN ENGLAND (Master of Public Health course, University of Edinburgh).

DOCTOR CAMILLE TCHUINKAM SIPZE

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Abstract

BACKGROUND.

Vasectomy is a minor surgical procedure to disrupt the vas deferens(tubes carrying spermatozoa from the testicles to the penis).Vasectomy uptake remains variable globally with scope for increased engagement in high income countries(Nicholas et al,2020).

OBJECTIVES.

- Demonstrate a cross disciplinary and critical understanding of barriers to promotion and uptake using evidence from psychology, economics, epidemiological and social disciplines.
- Explore barriers to promotion and uptake by:

a - Utilising skills acquired through the *Heath Promotion* course to assess levels of awareness.

b- Reflecting on the experiences of patients and providers.

c- Utilising skills learnt during the *Public Policy for Health* and *Research Design* courses to analyse existing vasectomy commissioning and referral policies.

METHOD.

- Rapid review of published literature to identify factors influencing access to vasectomy. Literature search focussed on statistics, sociocultural factors, commissioning and funding policies influencing promotion and referral processes. Search conducted on PubMed and Google Scholar, using PEO strategy.
- Conducting a stakeholders' analysis.
- Gathering views of practicing vasectomy surgeons through interviewing.
- Obtaining clarifications around vasectomy clinical guidelines, commissioning and referral policies from the Family Planning Association, and the Faculty of Sexual and Reproductive Healthcare.

CONCLUSIONS.

- A review of studies, policies and articles highlighted clinical and non-clinical factors influencing access to vasectomy

- Vasectomy uptake can be improved through an in-depth assessment to understand actual populations' needs ("bottom-up" approach) during commissioning/funding decision making. The Precede-Proceed Model(Green & Kreuter, 1991/2005) enables populations to influence decisions about their health needs(Porter et al, 2016).
- *Improving access to vasectomy is an incentive towards achieving equal sexual and reproductive rights. Barriers to vasectomy oppose articles 5, 6, 7, 8 and 9 of the IPPF Sexual Rights Declaration which sets entitlement related to sexuality that originates from rights to freedom, equality, privacy, autonomy, integrity and dignity of all people (IPPF Declaration,2006).*
- *REFERENCES AVAILABLE ON REQUEST*

P12

PlanUrFam – a pilot study in South Africa for a novel telemedicine contraceptive counseling service at the time of an abortion

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Abstract

Introduction

Contraceptive counseling and access to modern contraceptives are essential for reproductive health and equality. Telemedicine contraceptive counseling (TECC) could increase access but has not been tested replacing in person counseling. Our aim was to test the acceptability of a novel comprehensive tailored contraceptive counseling chatbot.

Methods

We conducted a mixed methods pilot study among 31 women seeking abortion at two public health clinics in South Africa. Participants used TECC to choose postabortion contraceptives. Follow-up occurred after two weeks. In-depth interviews were held with a nestled subgroup (n=8). We used a sequential explanatory design with equal weight, assessing acceptability using a validated framework for acceptability of healthcare interventions. Qualitative data was analysed using a hybrid approach (conventional inductive and directed deductive content analysis). Main outcomes were a compound variable of several measures of acceptability and secondary outcomes were choice and switch of contraceptive method.

Results

Participants were 25 years old (median), 61.5% were unemployed, and 41.9% lived in informal housing. Previous contraceptive use was 74,2%, of which progestin injection constituted 71%. After TECC, 64,3% chose LARC, and intervention acceptability was achieved among 89,3%. Qualitative findings and triangulation confirmed high acceptability and revealed complementary findings on benefits of TECC versus in-person care.

Discussion

Using TECC was highly acceptable to users and may increase choice of LARC. Larger trials are needed to assess the effectiveness of TECC on contraceptive uptake and use compared to in-person care.

P13

Perception of Contraception: Using festival theater to investigate the use, knowledge and attitudes toward contraception among young adults

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Abstract

Background and objectives: Considering the increasing interval between sexual debut and childbearing, effective and suitable contraception has become even more important for young adults. However, recent studies show decreased use of hormonal contraception, particularly among young adults. It is suggested that the role of social media may have influenced the perception of contraception. In this sex-positive educational research project, we used festival theater to investigate the use, knowledge, and attitudes toward contraception among young adults, with a specific focus on differences in sex, age and sexual partnership.

Method: Participants were recruited at a large music festival in the Netherlands. Through festival theater, visitors were asked to fill out an online questionnaire about the use of contraception, participated in a knowledge quiz about contraception, and wrote their experiences with contraception on a wall.

Results: The participants (N=1024) were on average 28.1 (SD=5.5) years old, 33.6% of them identified themselves as male and most of them (75.0%) had a permanent sexual partner. Most participants (91.3%) did something to prevent them from a pregnancy, including male condoms (37.4%), the hormonal intrauterine device (IUD) (33.2%), and the contraceptive pill (27.0%). Males were more satisfied with contraception than females (M=7.7 vs M=7.0; $p<0.01$), while females felt more responsible to use contraception (M=8.7 vs M=7.7; $p<0.01$), showed a greater importance of preventing a pregnancy (M=9.2 vs M=8.9; $p<0.01$), and had more knowledge about contraception than males (M=77.4 vs M=61.5; $p<0.01$).

Conclusions: The majority of young adults in our study used reliable contraceptive methods. They were relatively satisfied, felt responsible, thought it was important to prevent a pregnancy and were relatively knowledgeable. However, gender inequalities were seen in the attitudes toward and knowledge of contraception, illustrating a need to focus on both genders in sexual education.

P14

Yanae® a game changer in copper IUD insertion? Report of a challenging clinical case

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Abstract

Background: Yanae®, a copper IUD with an original insertor, based on CrossGlide™ technology, was specifically developed to facilitate cervical crossing during insertion and to fit every uterus shape. The innovative features of Yanae® insertor rely on a frictionless and flexible inflatable membrane. Its clinical benefit has been demonstrated in several studies and confirmed in real world evaluation. Yanae® has been used in France since May 2022.

Objectives: This case report describes a multiparous woman with complex uterine anatomy, who was proposed IUD insertion with Yanae® after two unsuccessful attempts with other IUDs using traditional rigid insertor.

Method: Patient clinical data, including gynaecological history, uterine anatomy, and IUD insertion attempts, were collected retrospectively by the health care provider who performed the insertions.

Case report: A 37-year-old woman, with two vaginal deliveries, desired to renew her copper IUD. Pelvic ultrasound showed anteverted retroflexed uterus with length of 9.3 cm. Two previous IUD insertion attempts employing a standard rigid insertor were unsuccessful despite tenaculum use. Both attempts failed due to a steep cervical angle. At the second attempt, the patient experienced severe pain causing cervical spasms. As the patient still wanted a copper IUD, a general anaesthesia was initially scheduled to perform the third attempt but Yanae® was finally proposed as an alternative option. Thanks to its specific insertor, IUD insertion was successfully and easily done without the need of a tenaculum. The patient experienced minimal pain during the procedure, and the correct position of the IUD was confirmed by pelvic ultrasound performed one week after.

Conclusions: This clinical case highlights the clinical benefit of Yanae® compared to other IUDs with standard rigid insertor. Yanae® allowed an easy, smooth, and painless IUD insertion. This innovative technology has dramatically changed the clinical journey of this patient by avoiding unnecessary and cumbersome hospitalization.

P15

Arabic Speaking Women's Views on Post-Partum Contraceptive Services in Sweden

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Abstract

Background

Immigrant women in Europe report lower use of contraception and have a higher incidence of abortions compared to native-born women. Little is known on how contraceptive services could be adapted to best meet the needs and preferences of immigrant women. Today approximately a third of all women giving birth in Sweden have an immigrant background. Considering the recent pattern of immigration to Sweden, Arabic speaking women are an important, nevertheless heterogenous, group to consider in reproductive health research.

Objectives

To explore Arabic speaking women's experiences of post-partum contraceptive counselling.

Method

This was a qualitative study, using focus group discussions (FGDs). A total of 23 women participated in the study. The FGDs were conducted in Arabic, audio-recorded, transcribed verbatim and then translated to English. The transcripts were coded double-blinded and analyzed using reflexive thematic analysis**.**

Results

Four main themes were created; *1)Adaptation to new circumstances influence family planning decisions, 2)Reproductive decision making - the women's choice but partners' support is important, 3)Conflicting information on contraceptives creates hesitancy and 4)Trust and mistrust in postpartum contraceptive services.*

As a way of managing stress from raising children in a new setting, child-spacing was described as essential for the entire family's wellbeing. Conflicting information on contraception from their home country and midwives in Sweden generated distrust. Difficulty to book appointments created a fear of using contraceptives, since the participants weren't confident that they would receive timely help

if experiencing side effects. Religious beliefs and partner involvement were seen as enablers for contraceptive use.

Conclusion

To establish a person-centered contraceptive counselling postpartum, there is a need to shift focus from individual barriers and push for organisational adaptations. Key aspects include incorporating the concept of child-spacing in the post-partum contraceptive counselling, ensuring accessible follow-up services and providing sufficient information in the native language.

P16

"These days women decide": contraceptive decision-making among IUD users in Uganda: A qualitative study

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Abstract

Background

The unmet need for contraceptives in Uganda remains high at 28%, and almost half of all pregnancies are unintended. While the use of long-acting reversible contraceptive methods, such as intrauterine devices (IUDs), can help prevent unwanted pregnancies, their use remains limited in Uganda. Furthermore, while there is ample evidence on the barriers to contraceptive use, less is known about the factors that facilitate it.

Objectives

To explore Ugandan women's experiences and perceptions relating to IUD use, including how they navigate socio-cultural factors, gender norms and power relations.

Method

Between January and August 2023, we conducted a qualitative study at four health facilities in and around Kampala, Uganda. Using purposive sampling, 24 women, 19 years and older, were recruited for in-depth interviews. The data were transcribed and coded in NVivo and analysed using thematic analysis.

Results

We found that participants who had initiated IUD use had a strong conviction that they had the right to make autonomous reproductive health decisions based on their financial situation, bodily integrity and pragmatic and rights-based arguments. Reproductive autonomy was complicated by traditional norms and stigma and misconceptions and rumours about contraceptives. Concealed IUD use and obtaining quality contraceptive counselling enabled the participants to achieve their reproductive goals, despite the barriers faced in relationships and communities.

Conclusions

This qualitative study suggests that reproductive norms in Uganda are shifting towards smaller family size and are perhaps also altering the power dynamics between men and women. Strategies to overcome identified barriers to contraceptive use include covert IUD use, which enables women to live by their more progressive norms while appearing to adhere to more traditional norms. Strengthening women's autonomy and self-sufficiency could be an important strategy for more women to initiate IUD use. Good-quality contraceptive counselling is vital to dispel myths and misconceptions.

P17

Can copper intra-uterine device (IUD) cause endometriosis?

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Abstract

She is a 23 years old nulliparous woman and received a copper IUD for her contraception. Clinical examination and ultrasound examination are normal. One year later, she is asymptomatic, her ultrasound examination shows a 5 centimeters long left ovarian endometrioma. She asks wether the copper IUD is involved in the endometrioma onset.

We aim to study the potential link between copper IUD and the secondary onset of endometriosis, given the increased popularity of non-hormonal contraception, especially in nulliparous women.

We carried out a literature review on PubMed, Google Scholar and Google, the last five years with keyword's endometriosis and copper IUD, iatrogenic endometriosis.

Copper IUD can trigger heavier and frequent periods , knowing that heavier periods may be a risk factor of endometriosis. A single study (2018) of JP Carrascosa & Al reports copper induced alteration of gene expression involved in decidualization, including 19 genes linked to endometriosis. According to K. Lombardi on the Drugwatch website, endometriosis may be a side-effect of Paragard* IUD, a copper IUD. On Google, a few women report their experience about endometriosis, diagnosed after using a copper IUD.

The contraception demand is evolving, driven by societal trends, such as the postponement of the age of the first pregnancy, ecological concerns about exogenous sex hormones, and searching to reduce the mental burden of daily contraception.

Endometriosis has long been overlooked, leading to frustration and lost of trust among those affected, who sometimes turn to self-proclamed experts and mercantile influences. According to our observation and literature review, the link between endometriosis and copper IUD cannot be ruled out.

We need to think ahead potential new health crisis. The link between copper IUD and endometriosis must now be the focus of careful studies.

P18

Leveraging Inbound Marketing Strategies to Bridge the Gap in Family Planning Information and Services in Pakistan

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Abstract

Background: Inbound Marketing Strategy (IMS) attracts potential clients by providing relevant content, making it easier for users to find desired information, goods, or services through search engines like Google. This study examines IMS's potential to address family planning (FP) needs in Pakistan by analyzing online search behavior.

Objectives: This study aims to assess the availability and authenticity of FP-related information and services online in Pakistan, focusing on frequently searched keywords on Google.

Data Source: In 2022, over 80% of online search traffic in Pakistan was through Google. Google Keyword Planner (GKP) was used to analyze FP-related keywords and their search volumes from January 2019 to June 2022.

Methodology: Sixteen top FP-related keywords were identified and analyzed, including terms like "contraceptive," "birth control," "condoms," and "family planning." Data from GKP yielded over 2000 keyword combinations, narrowed down to 146 relevant keywords with a minimum search volume of 100 per month. Each keyword's top 10 search results were evaluated based on website focus, type, services, organization, and origin country.

Results: Monthly search volume increased from 23,083 in 2019 to 96,640 in 2022, with 318% overall increase. Among the 1460 links analyzed, 179 (12%) were from Pakistani websites, with only 102 links being unique. Only 17 of these provided exclusive FP services, belonging to organizations like PWD, UNFPA Pakistan, Green Star, and DKT Pakistan. Additionally, seven links focused on condom sales and several online pharmacies and e-commerce stores offered various FP products.

Conclusions/Policy Implications: Organizations promoting FP services in Pakistan can enhance their visibility on Google by implementing IMS. Given that 2.35% of traffic from Google converts into clients, effective use of IMS could attract potential FP clients, addressing their FP needs in Pakistan. The study highlights a significant gap between online demand and supply of FP-related information and services in Pakistan.

P19

KNOWLEDGE OF CONTRACEPTIVE METHODS BY WOMEN CONSULTING FOR INDUCED ABORTION IN THE PARIS REGION

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Abstract

Background

In 2022, global contraceptive prevalence of any method of contraception was estimated at 65%. In France more than seven out of ten women of reproductive age use a medical method for their contraception (Baromètre Santé 2016).

While the number of contraceptive options keep on increasing since the legalisation of induced abortion in 1975, the annual number of induced abortions has remained rather stable over the last two decades in France (between 220,000 and 234,000).

Practical knowledge of contraceptive methods is one of the factors influencing unplanned pregnancies. However, no study was ever conducted on this topic in women requesting an induced abortion in the Paris region.

Objectives

Evaluation of the knowledge of contraceptive methods by women consulting for induced abortion.

Method

Multicentric, observational, descriptive, quantitative study carried out after ethics committee approval in five hospital-based family planning and abortion centres in the Paris region. A self-administered paper-based questionnaire on contraception was distributed to women coming for induced abortion before their consultation. Completed questionnaires were reviewed during the consultation with a physician or a midwife, thus helping patients to choose their post-abortion contraception to be prescribed. Approximately 500 questionnaires will be collected from January to June 2024.

Results

Preliminary results from 212 validated questionnaires show that there are no significant differences between the five centres with respect to socio-demographic data.

Women using the pill, vaginal ring, transdermal patch and LARC had significantly fewer induced abortions than others using condoms or natural methods (withdrawal, calendar method, etc).

The average score of correct answers is 56.9% overall.

Conclusions

Since the collection of questionnaires is still ongoing, final results and conclusions will be presented at the time of the congress. The potential relationships between the contraception used by women before requesting an induced abortion and their knowledge about it will be explored, too.

Counselling

P20

Exploring Somali-born women's experiences with post-partum contraceptive services in Sweden through a reproductive justice lens

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Abstract

Equitable contraceptive counselling is important for achieving sexual and reproductive health and rights. Immigrant women often experience insufficient contraceptive services and there is an overall lack of understanding how contraceptive services are optimal arranged and delivered in health systems. One of the largest immigrant group in Sweden is Somali-born women which have a higher risk of negative health outcomes while pregnant and during childbirth compared to Swedish-born women.

This study aimed to gain a deeper understanding of Somali-born women's perceptions of and experiences with postpartum contraceptive services in Sweden.

Eight focus group discussions were conducted by a Somali-speaking moderator. Data were analysed using Braun and Clarke's reflexive thematic analysis. All participants (*N* = 60) were born in Somalia and had given birth in Sweden.

Four main themes were constructed: (1) the community's role in informing individual reproductive intentions, (2) changing reproductive needs after migration, (3) willingness to receive contraceptive counselling and (4) sharing perspectives a way to improve contraceptive services.

The findings suggest reproductive injustice for Somali women in contraceptive services in Sweden. We generated insight on how to improve contraceptive counselling. Our findings extend beyond a Swedish context and have implications moving towards reproductive justice, including informed choice discussions and consent in the delivery of sexual and reproductive health counselling.

P21

Enhancing uptake of long-acting reversible contraception in young women: insights from the LOWE Trial

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Abstract

Background

Recognizing the importance of preventing unintended pregnancies in young persons, this study evaluates the impact of structured contraceptive counseling on the choice, initiation, and use of long-acting reversible contraception (LARC). The research is grounded in the backdrop of increasing recognition of LARC advantages among young populations and expanded access to LARC methods.

Objectives

To assess the impact of structured contraceptive counseling on young women's uptake regarding LARC, satisfaction with the intervention by the type of visit and, information on extended use of short-acting reversible contraception (SARC).

Method

The LOWE trial, a cluster randomized controlled trial conducted in Stockholm, Sweden during 2017-2020, enrolled women seeking contraceptive counseling or induced abortion with counseling included. A number of 28 abortion, youth and maternal health clinics participated. Clinics were randomized (1:1) to either structured (intervention) or standard counseling (control). The intervention included an educational video, four key questions, an effectiveness chart and, a toolbox with contraceptive models. Surveys were administered during clinic visits and at follow-ups.

Results

In the trial 1338 patients were enrolled, whereof 770 young women, 18-25 years of age, were included in this analysis of secondary outcomes.

The intervention led to a marked increase in LARC choice (aOR 5.96, 95% CI 3.25-10.94), initiation (aOR 4.43, 95% CI 2.32-8.46), and use (aOR 2.21, 95% CI 1.31-3.73). The intervention materials were well received, with higher satisfaction reported for the educational video (P=0.03), effectiveness chart (P=0.01) and box of models (P<0.01) during booked compared to drop-in visits. Among participants using SARCs, more in the intervention had received information about extended use regimen (133/143, 93%), compared to the control group (178/213, 83.6%, aOR 13.87, 95% CI 2.94-65.41, P<0.001).

Conclusions

Structured contraceptive counseling can serve as a model to enhance reproductive health services for young persons and enables shared decision-making and improves reproductive autonomy.

P22

Motivations for terminating or continuing an unwanted pregnancy: A scoping review of the literature

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Abstract

Background. Motivations for abortion are often a topic in political and public debates, and in some countries, policies are based on this. The aim of this scoping review was to give an overview of recent studies investigating self-reported motivations to terminate or continue an unwanted pregnancy in different countries and settings, including and evaluating both qualitative and quantitative results.

Objectives. To give an overview of recent studies investigating self-reported motivations to terminate or continue an unwanted pregnancy in different countries and settings, including and evaluating both qualitative and quantitative results.

Methods. We searched for peer-reviewed, English language publications published between 2008-2023 indexed in four scientific databases. Studies were included if they captured people's own motivations for terminating and/ or continuing an unwanted pregnancy.

Results. Of the included 19 studies, all focused on abortion, and four also focused on the decision to continue an unwanted pregnancy. Motivations for abortion were often related to family planning, the partner involved in the pregnancy, and life or material circumstances such as housing or future plans. Especially in countries with more restrictive abortion laws, stigma, shame, or negative reactions also played a role. Motivations to continue an unwanted pregnancy were often related to the partner as well, and to personal beliefs towards the pregnancy. Despite different settings, different methods, and methodological limitations, studies showed similar multifactorial and interrelated motivations in decision making around unwanted pregnancies.

Conclusions. This research showed that in different places throughout the world, multiple interrelated motivations play a role in a decision to terminate or continue an unwanted pregnancy. The findings mainly provide insight in retrospective explanatory accounts, which may be biased because respondents may feel the need to justify their choice. Future research should focus on connecting with lived experiences and move away from asking for reasons to rationalize unwanted pregnancy decisions.

P23

Women's opinion and experience of gynecological examination with sonography, abortion services, and telemedicine abortion: A Qualitative Study in Sweden

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Abstract

Context: According to Swedish law, abortion treatment should be carried out at an approved healthcare facility. All women seeking medical abortions are obliged to attend an in-person visit, which includes a pelvic examination, ultrasound scan, and the administration of mifepristone at a hospital/clinic. However, countries implemented telemedicine abortion services without the requirement of in-person visits during and after the COVID-19 pandemic.

Methods: We interviewed 20 participants who sought early medical abortion at the abortion clinic at Sahlgrenska University Hospital/Gothenburg, Sweden, from March to April 2023. Systematic text-condensation of qualitative semi-structured interviews was used to explore women's experience of pre-abortion visits, including gynecological examination and transvaginal ultrasound, thoughts about abortion care services, and telemedicine abortion.

Results: Four themes emerged: (1) Access to abortion services and waiting for the pre-abortion visit, including availability, feelings/emotions of waiting for the pre-abortion appointment, expectations before the visit, and experiences of waiting in the clinic waiting room, (2) experiences of the pre-abortion visit including experiences of the gynecological examination, seeing the ultrasound screen and contraceptive counseling, (3) opinions on telemedicine abortion provision, and (4) thoughts on taking mifepristone in-clinic or at home.

Conclusion: This study demonstrates that women are very satisfied with the abortion healthcare services in western Sweden, including in-person visits with gynecological and ultrasound examinations. Women found the pre-abortion visits important and person-centered, and they trusted the healthcare workers. However, access to telemedicine, including the flexibility of taking mifepristone at home, women thought was an important option to increase women's autonomy and empowerment.

P24

Layers and voices in decision-making about an unintended pregnancy

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Abstract

Per year, one in 16 people are faced with an unintended pregnancy. It is a life experience which often confronts a pregnant person with a difficult, stressful and irreversible decision to carry out or terminate the pregnancy. It is important for a person with an unintended pregnancy to make their own decision; the more it is their own choice the better they can move forward and give it a place in their life story.

The importance of making a well-informed decision is clear, but insights into how people with an unintended pregnancy come to a decision are lacking. Research so far is limited in applying a mere rational framework and focusing solely on the outcome of the unwanted pregnancy, i.e. reasons for and certainty about abortion, and not, for instance, continuation of the pregnancy.

We conducted a narrative literature review to gain insights into what is currently known about the major elements involved in the decision-making process of all persons with an unintended pregnancy. This study provides the insight that the decision-making process about an unintended pregnancy consists of navigating entangled layers instead of weighing separable elements. The layers – a sense of knowing, feelings and beliefs, interrelatedness, providers and policy and norms and social pressure – are both internal and external to the pregnant person. The sense of knowing seems to play an important part. This shows that a rational frame is inadequate, and a more holistic frame is needed to capture this dynamic and personal experience.

In two subsequent empirical studies we are collecting the experiences of people with decision-making regarding an unintended pregnancy using a mixed method approach.

I will present the outcomes of my studies so far and introduce the audience to the layers and voices in decision-making of people with an unintended pregnancy.

Education

P25

Adolescent Engagement with Sexual and Reproductive Health in Venezuela: A Participatory Mixed-Methods Analysis

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Abstract

Background: The protracted humanitarian crisis in Venezuela has severely impacted the lives of adolescents who face economic scarcity and limited access to education and healthcare. In this economically and legally restrictive context, Venezuelan youth face significant barriers to accessing sexual and reproductive health (SRH) information and resources, posing significant risks to overall health and well-being.

Objectives: We sought to better understand the SRH-related preferences, needs, and concerns of Venezuelan adolescents and explore their digital engagement with SRH content.

Method: This mixed-methods study was conducted between August 2022 and January 2023. Adolescents between the ages of 10 and 19 who lived in Venezuela and provided informed consent were included. Participants completed an exploratory survey focused on SRH-related education and resources. Those recruited for the qualitative component also participated in a photovoice cycle and in-depth interviews. Survey data was reported descriptively, and qualitative interview data was analyzed and coded thematically.

Results: A total of 207 adolescents completed the exploratory survey with 72.5% of participants aged 16 or older (n=150) and 73.4% (n=152) identifying as girls. Only 5.7% (n=12) of participants reported that they regularly engaged with SRH topics in school and 93.2% (n=193) reported that they frequently turned to digital technologies for this information. Twelve participants participated in the qualitative analysis, which identified three primary themes: 1) digital media filled gaps in SRH education, 2) misinformation around SRH was present in digital spaces, and 3) photovoice acted as an important space for self-expression and youth advocacy.

Conclusion: Venezuelan adolescents demonstrated resourcefulness in seeking out digital SRH information amidst a humanitarian context where reliable health resources are restricted. The participatory approach empowered participants to co-develop an online youth forum that offers evidence-based SRH information for Venezuelan adolescents. Further interventions are necessary to support the reproductive health and rights of adolescents in humanitarian settings.

P26

Using the Papaya Workshop for abortion training in Germany - a survey among participating medical students

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Abstract

Background: Papayas are an excellent and easily accessible uterine model to teach intrauterine procedures like manual vacuum aspiration or insertion of intrauterine devices. Since 2015, German "Medical Students for Choice" groups have been organizing extracurricular Papaya Workshops for their fellow students, under the supervision of doctors from "Doctors for Choice Germany".

Objective: Although Papaya Workshops are already quite established internationally, they are still a new concept in Germany. This survey aims to evaluate the workshop format and participants' satisfaction.

Method: Between May 2022 and December 2023, 17 Papaya Workshops were carried out. We asked all participants to take part in an online survey after attending the workshop. The questionnaire contained a total of 39 questions.

Results: 187 medical students from 24 German universities took part in the survey. 136 students (72%) were at least in their 4th year of medical school. 171 students (88%) rated abortion teaching at their university as inadequate, which was often the motivation for enrolling for the workshop. An overwhelming majority of participants (99%) highly valued the workshop, giving it the best or second best grade available (average grade: 1.3). 183 participants (97%) felt encouraged to engage further with the topic of abortion care. One in five students (23%) reported a change in their attitude towards abortion after the workshop. The majority of participants (80%) would like to provide abortions in their future practice.

Conclusion: This is the first study evaluating Papaya Workshops in Germany. Overall, satisfaction with Papaya Workshops among participating medical students is high. Our results suggest that using papayas as a simulation model positively affects students' attitudes towards abortion and encourages further engagement with the topic. This aligns with reports from various other countries, where Papaya Workshops have already been successfully implemented in the curriculum to teach uterine aspiration procedures to (future) doctors.

P27

Addressing the Abortion Knowledge Gap: E-Learning Initiatives for Healthcare Providers Training

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Abstract

Medical abortions are safe and effective, with healthcare workers playing a crucial role in their provision. Despite this, there is a global gap in abortion education among providers. WHO's 2023 report reveals that many medical and nursing programs, especially in the Global South, lack comprehensive abortion training. Research shows half of U.S. medical schools offer minimal or no abortion training, and UK medical students receive less than two hours of clinical teaching on abortion. This educational gap hinders the provision of safe, accessible abortion care worldwide.

To address the need for well-trained abortion providers, HowToUse (HTU) and the International Planned Parenthood Federation (IPPF) developed a free, comprehensive online course on medical abortions. Targeting healthcare workers like doctors, nurses, midwives, doulas, and health educators, the course is available in 13 languages and is endorsed by the International Federation of Gynecology and Obstetrics (FIGO). This course fills a crucial educational gap, as abortion care is often excluded from medical training curriculums.

HowToUse and IPPF surveyed 91 participants, including medical students, nurses, community health workers, and other medical professionals who completed the course, to assess its effectiveness and impact on their practice and support for abortion seekers.

The course had certified 13,000 providers globally. Among 91 surveyed participants, 91% reported an improved ability to support medical abortions, with 68% noting immediate work benefits. Additionally, 49% appreciated the concise, practical format and comprehensive content, and nearly all (99%) would recommend it to other healthcare workers. Participants also expressed interest in further training on abortion guidelines, MVA, and SRH.

The results of the study highlight the critical need to integrate medical abortion care into medical education, ensuring a skilled and willing workforce capable of providing safe abortion services. The positive feedback from course participants underscores the effectiveness of well-structured eLearning programs in addressing knowledge gaps.

P28

Introducing the Abortion Framing Toolkit: Rethinking Abortion Messages for Social Changes

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Abstract

1. **Background**

Our collective beliefs and worldviews are often shaped by the narratives around us, especially in the context of abortion care. Each communication piece, whether social media posts, press releases, images, emails, or educational materials, frames abortion, influencing one's attitude and perception of abortion.

1. **Objectives**

This paper introduces the Abortion Framing Toolkit developed by Women on Web, aimed to inspire and guide those in the abortion movement in crafting intentional and supportive messages around abortion.

1. **Method**

The toolkit's development followed a multi-step process, aligning with best practices for practicality and reliability. The framework was shaped by the communication needs of Women on Web and 11 IPPF Members involved in the Global Care Project. The toolkit combines methodologies from ILGA-Europe's Framing Equality Toolkit and IPPF's Winning Narrative e-Course. The core chapter on "12 Common Perspectives" draws from an extensive literature and desk review, ensuring diverse representation. Reviewed by a select group of international abortion activists, the toolkit was translated into French, Spanish, and Thai to enhance accessibility.

1. **Results**

Since its publication in late 2023, the toolkit has travelled globally. It was introduced to over 80 Safe Abortion Action Fund (SAAF) grantees and utilized in numerous workshops and campaigns in various countries including Brazil, Colombia, the Democratic Republic of Congo, Germany, Honduras, Indonesia, and Kenya. Moreover, organizations have adapted the toolkit to fit their specific needs and contexts, including translation into local languages, highlighting its versatility and usability.

1. **Conclusions**

The toolkit underscores the critical role of strategic communication in shaping abortion discourse and highlights the significant impact framing has on sexual and reproductive health and rights. It serves as a vital tool to transform harmful norms, create new narratives, tackle stigma, and facilitate the empowerment of individuals to make informed decisions about their bodies.

Emergency contraception

P29

Access to Emergency Contraception in Fijian Community Pharmacies

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Abstract

Background: Little is known about the provision of emergency contraceptive pills (ECP) over the counter through pharmacies in Fiji. This project aimed to identify the ECP knowledge and practices of pharmacists during the provision of contraception relation point-of-care information, counselling and referral.

Objective: To assess pharmacists' knowledge regarding emergency contraceptive pills (ECPs), their attitudes toward women obtaining ECPs, and ECP counselling and dispensing practices.

Methods: An online cross-sectional survey using Qualtrics was distributed via pharmacy emails and networks to recruit registered pharmacists working in community-based pharmacies.

Results: There were 22 valid respondents, predominantly female pharmacists (68%), with an average of 7.5 years of registration. All pharmacists knew the correct time frame after unprotected sex for ECPs to be effective and 73% knew how ECPs worked, but only 50% knew that there were no contraindications. Most pharmacists (86%) knew that ECPs should be available to all women and girls but only 59% thought that a married women should not have to get permission from her husband to buy ECPs. Information or education for clients on the correct use of ECPs was mainly provided by pharmacists (59%), mostly through verbal communication (96%). Only 5% of pharmacists had used the Emergency Contraception Methods Wheels.

Conclusions: There were gaps in pharmacists' knowledge regarding ECPs. Biases, judgemental attitudes, and sub-optimal practices existed. Targeted education and training for pharmacists is needed to improve access to ECPs in Fiji.

P30

The cost of emergency contraception pills in Central and Eastern Europe: An essential reproductive health supply or a luxury product?

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Abstract

Background

Emergency contraception pills (ECPs) are largely procured through the private sector in Europe, and paid out of pocket by users. A basic analysis of the prices of levonorgestrel EC pills in Central and Eastern Europe countries (CEE), conducted by the European Consortium for Emergency Contraception (ECEC) in 2017, suggested that out-of-pocket costs for ECPs are higher. In some CEE countries, women spend between 2 and 3 % of the Gross Average Monthly Wage (GAMW) to buy one ECP. In Western European countries, the absolute price of EC pills is higher, but the relative cost is significantly lower: less than 0.5% of the GAMW. This gap in out-of-pocket costs deepens inequalities in access to reproductive health care.

Objectives

The Central and Eastern European Network for Sexual and Reproductive Health and Rights (ASTRA) and ECEC want to generate knowledge on the economic barriers to ECPs in CEE countries, and are conducting a participatory survey to collect data on cost of ECPs in 2024 and gratuity schemes in CEE countries.

Methodology

An on-line questionnaire has been developed. From June to July 2024, data from 20 CEE countries will be gathered: EC pills availability (LNG, UPA, mifepristone); registration status (Rx/BTC/OTC); price; gratuity policies; availability of updated guidelines and of data on EC use. Collected data will be systematized and published on ECEC website. An analysis of absolute vs relative cost of ECPs in Western Europe and CEE countries will be run.

Results

Our hypothesis is that a significant relative cost gap persists.

Conclusion

There is a need to generate knowledge about the financial barriers to ECPs that are specific to the CEE subregion, in order to inform advocacy work. A recent case in the United Kingdom proved that strategic campaigns can successfully lead to ECPs price reduction.

P31

Levonorgestrel 1,5 mg Morning-After Pill: Risk of Meningioma?

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Abstract

Morning-after pill is widely used worldwide. Two different products are available: Levonorgestrel (LNG) 1,5 mg and Ulipristal acetate 30 mg.

LNG 1,5 mg is usually sold over the counter. It contains 50 times more LNG than the daily pill LNG 0,03 mg (Microval*) Do the various countries, where this drug is disponible, keep data on it?

This work aims to highlight the Levonorgestrel morning-after pill use, usually sold over the counter, given that some progestins are implicated in the risk of meningioma.

Do we need to draw up new recommendations concerning morning-after pill in the light of these data?

Should we think again about hormonal contraception over the counter, taking in account that an accessible and daily hormonal contraception provide more health benefits than a morning-after pill, repeatedly taken?

Literature review on PubMed and Google Scholar for the last five years with the keywords progestins,and meningioma, Lévonorgestrel and méningioma.

Increased meningioma risk was first linked to cyproterone acetate, then to chlormadinone nomegestrol, medrogestone, promegestone and medroyprogesterone.The increased risk of meningioma with several progestins raises fears of a class effect involving all progestogens. 2,2 millions of morning-after pills are sold each years in France, 2/3 of which are LNG 1,5 mg.

A recent large-scale french epidemiological study of meningiomas after surgery reported no increased risk with the LNG IUD, bearing in mind that surgery is not systematically required after discontinuation of progestin therapy. Nevertheless, some papers do not rule out the link between LNG and meningioma, including LNG contraceptive implant.

LNG morning-after pill seems to have been overlooked in the recommendations concerning progestins. LNG morning-after pill can be taken several times a month, especially by young people, despite the warnings in the package insert, which are rarely read. Further studies are required to clarify LNG morning-after pill risks.

Health Care Professionals

P32

Long-acting reversible contraception and medication abortion: a descriptive survey of primary care clinician knowledge, attitudes and practices

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Abstract

Background

Long-acting reversible contraception (LARC) and medication abortion (MA) provision in primary care is limited. General practitioners (GPs), practice nurses (PNs), and community pharmacists (CPs) are well-positioned to support the prevention and/or management of an unintended pregnancy. Primary care LARC and MA services can be impacted by issues including misinformation, stigma, and mentoring.

Objective

To investigate the knowledge, attitudes, and practices of GPs, PNs, and CPs about LARC and MA.

Method

As part of a mixed-methods project, an online survey of Australian GPs, PNs, and CPs was conducted from July until October 2021. Data were analysed using counts and proportions.

Results

Survey participants included 499 GPs, 489 PNs, and 533 CPs. IUD suitability for nulliparous women (GP:92%,PN:63%,CP:66%) and the superior contraceptive effectiveness of LARCs over the pill was known by most (GP:98%,PN:87%,CP:88%). During contraceptive consultations, 86% of GP participants discussed LARC very often/always, contrasting with PNs (26%) and CPs (11%). Few GPs (27%) and PNs (7%) inserted IUDs with most inserting 1-5/month. GP participants generally referred women to a private gynaecologist (46%). More participants provided implant insertions (GP:76%,PN:19%), with most inserting 1-5/month.

While MA provision was acceptable to most (GPs:82%,PNs:71%,CPs:91%), few perceived they had adequate knowledge to counsel patients about this, particularly PNs (GP:54%,PN:16%,CP:66%). Most

did not know/gave the incorrect order of MA administration (GP:65%,PN:80%,CP:57%). Many did not know/were unsure about the Australian regulatory 63-day gestational MA provision limit (GP:39%,PN:54%,CP:51%). 23% of GPs were MA providers, delivering an average of 5 MAs/month (SD=10.6). 9% of PNs were involved in MA care. 30% of CPs dispensed MA an average of 1.4 times/month (SD=2.5).

Conclusions

Few Australian primary care clinicians provide IUD/MA services. Those that do provide low numbers. To ensure enhanced LARC/MA access, clinician capacity-building and ongoing support are required for improved knowledge and confidence.

P33

Family Planning Expert Interventions in Criminal-Legal Proceedings

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Abstract

Background: Women and gender diverse people (WGDP) experiencing criminalization and incarceration in Canada experience high rates of unintended pregnancy, unmet contraceptive needs, abortion and fertility. Pregnancy while incarcerated is associated with inadequate prenatal care and higher risk of premature birth. Postpartum, WGDP are usually separated from their children, resulting in emotional distress, low breastfeeding rates, and disordered attachment. Despite United Nations rules governing the treatment of women prisoners that require consideration of gender and caregiving responsibilities, Canadian courts and prison policies and procedures fail to account for the lived realities and needs of WGDP regarding pregnancy.

Objectives: This presentation describes the presenter's experience providing advocacy, clinical opinion and expert testimony with respect to reproductive health needs in the context of criminal-legal proceedings including human rights tribunals, bail hearings, trials, sentencing and parole.

Method: In collaboration with frontline community organizations and legal aid defense counsel, over the past ten years, the presenter has prepared clinical opinion letters, court companionship, and expert testimony with respect to reproductive health considerations of relevance to custodial decisions. This presentation describes these approaches.

Results: Compelling expert contributions have the potential to prompt courts to move towards non-custodial options, reducing reliance on pregnancy termination to avoid pregnancy in custody, the clinical harms associated with pregnancy in custody, and the harms to children associated with parental incarceration. These contributions may come in various forms. From experience, the presenter will share strategies to engage in this work, how It is important for clinical experts to develop familiarity with criminal-legal procedures and norms, firmly establish their credentials, ideally interview the client concerned to individualize assessment, and incorporate consideration of intersectional and systemic oppression including racism and homo/transphobia.

Conclusion: Reproductive health experts can contribute meaningful to efforts to reduce the harms of incarceration through interventions in the criminal-legal system.

P34

What do Australian primary care clinicians need to provide long-acting reversible contraception and early medical abortion?

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Abstract

Background: Uptake of long-acting reversible contraception (LARC) is lower in Australia compared with other high-income countries, and only 11% of Australian General Practitioners (GPs) provide early medical abortion (EMA). The AusCAPPS (Australian Contraception and Abortion Primary Care Practitioner Support) Network is a virtual Community of Practice established to support GPs, nurses and pharmacists to provide LARC and EMA in primary care. Evaluating how participants engage with AusCAPPS presents an opportunity to understand clinician needs in relation to LARC and EMA care.

Objectives: 1) To evaluate participant engagement in the AusCAPPS virtual Community of Practice. 2) To describe key concerns and practical and professional needs of GPs, nurses and pharmacists in relation to LARC and EMA provision.

Method: Data were collected from July 2021 until July 2023. Numbers of online resource views on AusCAPPS were analysed descriptively and text from participant posts underwent qualitative content analysis.

Results: In mid-2023 AusCAPPS had 1911 members; 1133 (59%) GPs, 439 (23%) pharmacists and 272 (14%) nurses. Concise point-of-care documents were the most frequently viewed resource type. Of the 655 posts, most were created by GPs (532, 81%) followed by nurses (88, 13%) then pharmacists (16, 2%). GPs most commonly posted about clinical issues (263, 49% of GP posts) such as EMA risks and side effects. Nurses posted most frequently about service implementation (24, 27% of nurse posts) such as models of care for EMA. Pharmacists posted most about health system and regulatory issues (7, 44% of pharmacist posts) such as contraceptive availability and shortages.

Conclusions: GPs, nurses and pharmacists each have professional needs for peer support and resources to initiate or continue LARC and EMA care, with GPs in particular seeking further clinical education and upskilling. Development of resources, training and implementation support may improve LARC and EMA provision in Australian primary care.

P35

Recommendations for family planning care for people who experience incarceration: Findings from a qualitative study in Canada

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Abstract

Background: Women comprise less than 10% of prisoners in Canada. Existing research suggests prison is a barrier to sexual and reproductive health care, and incarcerated women experience high rates of unmet contraceptive need and higher lifetime rates of abortion than the average in Canada. People in prison face significant barriers to parenting, routine separation from children, vulnerability to permanent loss of custody, with impacts on family planning decisions. Family planning professionals are unlikely to have received training about the care of people in prison or who have experienced criminalization, and no health professional organization in Canada provides guidance on sexual and reproductive care for this population.

Objectives: To explore abortion and contraception care experiences of formerly incarcerated people and to inform recommendations for practice among family planning professionals in the care of people experiencing criminalization.

Methods: In partnership with community organizations supporting women and gender diverse people experiencing criminalization, we conducted six qualitative focus groups in four provinces across Canada with formerly incarcerated people (n=35). Anonymized transcripts were analyzed for key themes.

Results: Themes included: 1) Competing health needs; 2) Institutional barriers to care; 3) Mistreatment and unethical care; 4) Health knowledge gaps; and 5) Challenges to care-seeking in community. Family planning professionals should recognize the disproportionate experience and burdens of mental illness and substance use among incarcerated people; understand the impact of prior negative experiences of care on care-seeking; accept the serious limitations to health education in the prison context; and appreciate the impact of post-release challenges such as displacement and housing precarity.

Conclusion: Findings support recommendations for clinical practice and may inform development of guidelines and professional organization position statements for care of incarcerated people.

P36

Improving Abortion Access and Experience through Youth-led Research: Results from the CART-Access Project

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Abstract

Background: Though legal and available in Canada, disparities exist regarding how accessible and affirming abortion care is for equity-deserving groups, including youth.

Objectives: This project sought to identify new ways of making abortion information and services more accessible and comfortable for equity-deserving groups across Canada. By empowering youth researchers to lead such efforts, new insights and interpretations from youths' intersectional perspectives could enrich resources and approaches to delivering abortion information and care.

Methods: Youth Wellness Lab (YWL) youth researchers (age 29 and under) engaged a diverse sample of 45 family planning professionals (e.g., pharmacists, family physicians, OB-GYNs, nurses, midwives, social workers, abortion navigators) from across Canada in focus groups and individual interviews. In these conversations, youth “flipped the script” by steering discussions with adult professionals to explore how services and approaches might be more optimally designed to provide affirming and judgment-free abortion information and care, *by, with*, and *for* equity-deserving groups, including youth. Youth researchers were mentored to analyze qualitative data using a reflexive thematic approach. Youth then developed infographics and other easy-to-use abortion information and referral tools for both providers and abortion-seekers to use, respectively.

Results: Findings suggest that more resources are especially needed to support: 1) safe and non-judgmental abortion care for transgender and non-binary individuals; 2) youths’ full understanding of their rights to privacy and confidentiality in abortion care; and 3) abortion training and professional development opportunities for non-medical professionals such as social workers.

Conclusions: New knowledges created and shared by youth researchers bring fresh insights and relevant tools that may advance abortion access and experience for equity-deserving groups across Canada.

P37

Abortion knowledge production: learning about abortion care in Northern Ireland from the standpoint of nurses and midwives

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Abstract

Nurses and midwives provide abortion information, support, medication, or procedures to meet abortion patients' needs and according to legislation. Research shows that they are safe and acceptable providers when trained (Barnard et al., 2015; Mainey et al., 2020; Renner et al., 2013). In 2020, shortly after decriminalizing abortion, Northern Ireland introduced new legislation permitting nurses and midwives to autonomously provide abortion care. In this study, I ask: in the context of abortion law reforms, how are nurses and midwives learning about and sharing abortion knowledge? I use institutional ethnography to explore the dialogues and texts that mediate abortion knowledge, and how they are activated through the subjectivities of nurses and midwives. Based on a preliminary analysis of stakeholder interviews, a survey with 137 nurses and midwives and qualitative longitudinal interviews with three nurses and two midwives in 2023, I learnt how nurses and midwives produce embodied abortion knowledge through informal interactions and experiences with patients. However, I argue that these knowledges are discredited by institutions of work and learning. Interview data showed that senior staff may not take testimonies of abortion patient needs seriously in staff meetings. Nurses claimed that advocating for patients was more challenging from the bottom of the "pecking order" and that abortion care needs were seen as "an emotional thing". A midwife interview participant said that patients' needs were documented in formats and by staff removed from the local knowledges of midwives in Northern Ireland. This study suggests that nurses and midwives may not by recognised by the health system as credible learners and vectors of abortion knowledge, presenting a risk to the implementation of abortion law. Health systems in Northern Ireland and other settings introducing abortion law reforms should consider how training can harness localised and embodied forms of reproductive health knowledge.

P38

"How nice it would be if it were like that!" Synergies between pro-choice physicians and abortion accompaniers in Mexico.

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Abstract

Background

Joining forces and resources is required to achieve objectives such as access to safe abortion for all people. Synergy is a desired feature of collaborations because it enhances effectiveness and impact. In Latin America, both physicians and *acompañantes*, feminist activists who accompany self-managed abortions, play an important role in access to safe abortion, however, examples of successful collaborations are limited.

Objective

In this study, we explore the possibility of synergistic collaborations between pro-choice physicians and *acompañantes* in Mexico.

Method

This qualitative research parts from feminist epistemology. The data arose from three workshops with a gender and health perspective, in which 12 members of the Mexican Network of Female Pro-choice Physicians and 13 *acompañantes*, all cis-women, participated. The workshops were held in Mexico City, Chiapas, and Baja California states. They sought to foster sensitization and reflection on interactions, collaborations, and synergy between physicians and *acompañantes*.

Results

Within the 'synergistic collaboration' theme, we identified a common interest in building partnerships, concrete ideas about synergistic collaborations related to abortion care, and an interest in mutual care that arose from the recognition of gender-based violence that participants face. In the 'conditions for collaborations' theme, participants describe that combating prejudice and the creation of mutual recognition is necessary to build collaborations. The asymmetry in power between physicians and *acompañantes* is the main barrier to synergy. *Acompañantes* understand the value of medical knowledge, and although physicians appreciate the activists' work, they do not consider incorporating the accompaniers´ knowledge into their practices. The final theme 'workshop effects' describes an awareness-raising that could foster subsequent partnerships.

Conclusions

It is important to create spaces that facilitate meetings and exchanges to bring together these actors from different worlds, as collaborations between pro-choice physicians and *acompañantes* have the potential to be synergistic and, therefore, facilitate access to safe abortions.

P39

Research engagement within an independent abortion service provider: Considerations for effective communication

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Abstract

Background: Health care systems with an embedded research culture have better patient outcomes, more innovation, and offer research opportunities to the workforce. The British Pregnancy Advisory Service (BPAS) is the leading independent abortion provider in the UK, providing more than 100,000 abortions per year, largely under contract to the NHS. We are expected to deliver high-volume care, which presents challenges to embedding research across the organisation. An important enabler of an embedded research culture is transparent and accessible communication between the research and clinical functions. To facilitate a culture of research at BPAS, we aimed to understand how to develop our cross-functional research communication.

Objectives: We aimed to engage with BPAS staff to understand the desire for research and development areas for effective research communications.

Methods: We conducted a staff survey which was open to all clinical and non-clinical BPAS staff. Descriptive statistics were summarised.

Results: Thirty eight participants took part in our survey. Most held clinical positions (26, 68%), though there was representation from staff in business development, operations and external affairs. Staff overwhelmingly felt that receiving research communications was somewhat or extremely important to their role (36, 95%). More than half of respondents (20, 52%) preferred presentations from researchers at team meetings to learn about research, and were most interested in hearing about ongoing research projects (21, 55%) and involvement opportunities (10, 16%). Most respondents wanted to hear about research as regularly as monthly (22, 58%). Respondents proposed integrating cross-functional research leads into the organisation, acting as liaisons between their team and the research team, as an effective way to improve research communication.

Conclusions: Abortion providers and support staff within UK abortion services want to regularly learn about research activities. However, consideration must be given to communications strategies that offer appropriate, accessible and personalised outreach to diverse stakeholders.

P40

"They need to know that they have the right to choose". Mexican prochoice physicians' model of care.

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Abstract

Background

The existence of abortion pills has changed access to safe abortion globally. Self-management has led abortion care to become more demedicalized, challenges existing patriarchal power structures, and promotes autonomy. Clinical abortion care is firmly rooted within the hegemonic medical model but has moved towards demedicalization under influence of evidence on self-management practices, as reflected by the latest WHO guidelines on abortion care. However, little is known about prochoice physicians' current model of care.

Objective

We describe the pro-choice physicians' model of care in Mexico.

Methods

This qualitative study is grounded in feminist epistemology. We obtained data by interviewing 17 physicians, who identified as cis-women and members of the Mexican Network for Prochoice Female Physicians, from Mexico City, Chiapas, and Baja California states. Participants worked in the public (4) or private (9) sector, or both (4). We asked participants to describe their routine abortion-care practice and analyzed indicators of (de)medicalization, control, and autonomy.

Results

The prochoice physicians' model of care exists on a range within the model of hegemonic medicine but moves towards demedicalization and respect for autonomy limited by medical structures and protocols. Physicians share an understanding of how sociocultural and economic conditions limit access and influence the abortion process and describe emotional accompaniment to form part of their care. They respect individuals' decisions as well as their right to abortion at any gestational age. Working in the public or private sector did not determine level of medicalization. A subgroup of physicians fosters a feminist model of care which includes promoting social change through destigmatization and a human rights discourse.

Conclusions

Our findings suggest that the global influence of the self-managed abortion movement has reached Mexican prochoice physicians as they are moving towards a demedicalized practice that allows for increased autonomy, greater access, and more holistic care.

Historical Aspects

P41

Abortion care in Francophone Belgium

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Abstract

Abortion care in francophone Belgium is profoundly marked by the feminist movements of the 70's and it impacts the abortion care until today. With this presentation we wish to highlight the history of abortion care and abortion movements over the last 50 years in francophone Belgium, examining how the 20 years of illegal but open practice, influenced the law and current practices. In Belgium currently more than 80 % of abortions are done in family planning or abortion centres. We will explain how after 45 years GACEHPA (The Action Group for Extra-Hospital Abortion Centres) continues to ensure the quality of care by organising the training for abortion providers and ensuring that updated scientific guidelines are available for abortion practitioners.

Proposing abortion care in structures with multidisciplinary teams that offer broad sexual and reproductive health care services and prevention activities has been an non-negligible advantage both for professionals and patients. As aimed in the 70's our centres keep a very close proximity with patients. They are unique for their informal, familiar and demedicalised looks. The presentation will also detail the current practices of surgical abortion under local anaesthesia as well as medical abortion. We will conclude the presentation with the challenges for the future, ensuring the quality of care, choice of methods and the expansion of the abortion care after 14 weeks in an extra-hospital centre.

P42

Navigating medicalization and demedicalization in abortion care: the case of Women on Web

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Abstract

Women and pregnant people have self-managed their abortions across history and continue to do so regardless of legal contexts. The demedicalization of abortion represents an important discussion in how society and health professionals approach abortion care. Recent policy reforms and recommendations regarding self-managed abortion and demedicalized clinical protocols, especially regarding telemedicine, are influenced by the practice of self-managed medication abortion and the experience of grassroots-activism. Demedicalization may expand access to safe abortion as well as overturn existing power balances.

With over 15 years of operation, Women on Web has been at the forefront of enabling access to safe online abortion care for individuals worldwide. Given its mission, Women on Web has worked to make abortion accessible to everyone, particularly to those who cannot access it due to legal barriers. Working directly with abortion seekers, medical doctors, and helpdesk members at Women on Web, we frequently find ourselves at the crossroads of discussions and demands around self-managed abortion, telemedicine abortion, and demedicalization/medicalization, both as they pertain to those who seek and provide abortions.

In this work, we focus on the demedicalization of abortion and discuss how this trend has influenced our work over the years. Drawing on the experience of Women on Web, we present insights into the historical changes and contemporary landscape of demedicalized abortion care We argue that demedicalization/medicalization occurs across a spectrum and present examples of demedicalization within our own work, whilst recognising that medicalization and demedicalization may occur simultaneously. We discuss the changing trends and some challenges of navigating medicalization and demedicalization in abortion care.

P43

A SMALL HISTORY OF RU486 IN THE LARGEST OBSTETRIC-GYNECOLOGICAL HOSPITAL

Dr. Silvio Viale

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Abstract

In 1999 abortion was legal in 13 of the 15 countries of the European Union, not in Ireland and Portugal, but RU486 was only used in France, the United Kingdom and Sweden. Although abortion was legal, Italy was excluded from European registration of RU486 in countries where abortion was legal. It was for "political reasons", as the government argued that Italian law did not allow it.

In September 2000 I presented a question to the Turin city council to introduce medical abortion and the same was done in the Piedmont regional council. The response was that the law provides for "an update on the use of the most modern techniques, more respectful of the physical and mental integrity of the woman and less risky for the termination of pregnancy".

In January 2001 I asked to introduce medical abortion at the Sant'Anna Hospital in Turin. Since the proposal included also missed abortion it was signed by 100 gynaecologists, 52 objectors and 48 non-objectors, out of 118.

After years of polemics, delays and attempts of the health minister to stop it, we managed to start with the first medical abortion on 8th September 2005. Although the clinical trial was stopped before the end, the ice was broken, and European registration was finally requested in March 2007. Instead of the expected 90 days the application at the Italian Medicines Agency (AIFA) took 33 months and was concluded in December 2009. Ten years after the first request in 2000, RU486 was finally available for clinical practice in March 2010.

During this story up to April 2024 at the Sant'Anna hospital in Turin we carried out 24,335 procedures with the RU486, 17,009 abortions, 3,755 internal abortions and 3,451 second trimester abortions and missed second. Today, medical abortion with RU486 represents 74% of first trimester abortion.

Initiatives Politics and Society

P44

Constellations, crises and care: the role of Women Help Women in COVID19-shaped abortion trajectories

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Abstract

COVID-19, while exacerbating persistent social and structural inequities that shape and influence healthcare including abortion, also made self-managed abortion (SMA) more visible. Lockdowns altered conditions (economic, social, political) and prior conceptualisations of abortion as always requiring medical oversight. Self-administered MA as a viable and valid method was legitimised for gatekeepers - policymakers and medical professionals - that define “acceptable” abortion methods. This shift reframed SMA potentially enabling agency and autonomy even under restrictive conditions.

In Poland, the cumulative impact of the pandemic and the de facto abortion ban (October 2020) further complicated abortion trajectories. Women Help Women (WHW) is a feminist organisation providing abortion support globally. We analysed quantitative and qualitative data from Polish abortion requests for support from WHW’s online consultations during COVID-19 [April-Dec 2020].

Our analyses of qualitative email communications and quantitative consultation data forms (n=8,577) shows the impact of the crises on access to abortion and the role of WHW as a fundamental component of the constellation of actors that—working locally and transnationally—enabled safe(r) SMA trajectories. SMA appears as a potential means to circumvent or grapple with the crises in a way that centres the needs of abortion seekers and gives meaning to the technologies–telehealth and self-management. Care-seekers’ expressions of commitments and actions to support abortion also highlights the transformative power of feminist care ethics and resistance. Building on this, we show how the support provided by WHW is a critical factor in enabling safe(r) abortion trajectories but is also essential to challenging and altering the meanings of abortion and abortion provision itself. This project gives us insights into how technologies, their use and effects are both resisted and appropriated by activists organising for self-managed abortion.

P45

Safe Access Zones for abortion: can national legislation be enacted and is it beneficial to service users and providers?

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Abstract

Background

Apart from in states with repressive regimes, there has been shown to be a general need for Safe Access Zones (SAZs) in order to guarantee physical access to abortion services without harassment. Harassment by protestors violates the right to seek sexual and reproductive health services and information. Protests have significant detrimental effects on both patients and healthcare staff. Safe Access Zones usually operate for a prescribed radius around a clinic and lay down what behaviour is prohibited.

Objectives

To determine the feasibility of nationwide legislation for SAZs.

To determine the jurisdictions which have successfully legislated for SAZs.

To determine whether such legislation withstands legal appeals and is an effective countermeasure to protestors.

Method

Interrogation of parliament and government websites and medicolegal literature.

A literature review of studies of a) service provider views on benefits of SAZ legislation post-enactment and b) reports of prosecutions and appeals under SAZ laws.

Results

In 23 jurisdictions SAZ statute law had been successfully enacted. In a further four jurisdictions, a law was going through parliament or had not yet come into force. Countries with SAZ laws include Australia and New Zealand and parts of Canada, the USA and the UK.

Evidence from Australia and Canada confirmed that SAZs had been beneficial for patients and staff. Prosecution of protestors who breached SAZs in two Australian States and one Canadian Province was successful. The SAZ provisions in both Australia and Canada were upheld at appeal as constitutionally valid. In the USA the Supreme Court found SAZs to be unconstitutional in 2014.

Conclusions

SAZ legislation is worth advocating for. It benefits both service users and providers and sends a strong signal to those who might contemplate interfering with access to abortion that they will likely be prosecuted and punished under the criminal legal system.

P46

Crafting the ideal abortion law for Catalonia utilizing a feminist legal perspective

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Abstract

Background

Catalonia is an autonomous community in northeastern Spain with a devolved government. As such, they are subject to existing Spanish abortion legislation.

Objectives

L'Associació de Drets Sexuals i Reproductius is a non-governmental organization based in Barcelona which was approached by legal activists to write and introduce an abortion law in the Catalan Parliament addressing the shortcomings of existing Spanish legislation and proposing additional safeguards for sexual and reproductive rights.

Methods

A list of proposed components for the law were drafted. A review of relevant literature and scholarly sources was conducted to compile examples of practical experience in countries around the world and recommendations from international health organizations. Current Spanish laws were reviewed to determine which proposed components of the Catalan law would require legal changes.

Results

The final law consisted of evidence-based proposals for: decriminalization, elimination of term limits, elimination of individual and institutional conscientious objection, no parental authorization for minors 14+, abortions provided free of charge (regardless of immigration status) in the public health system, safe access zones, provision of telemedicine abortion (including no-test), provision of mifepristone and misoprostol in pharmacies and via home delivery, mandatory abortion training for doctors and midwives, provision of abortions by midwives or doctors (of any specialty) with training, emotional accompaniment for abortions, processes to ensure high-quality abortion care, and others. This law was registered in the Catalan Parliament on 7 March 2024 and is awaiting debate.

Conclusions

The objective of this initiative was to bring an abortion law with significantly expanded protections into parliamentary discussion and debate. If this law is able to gain support within Catalonia, it is possible that additional efforts to expand abortion protections at the national level would be introduced, and the components of the proposed law which do not supersede existing Spanish legislation may be adopted.

P47

Mandatory spousal authorisation of abortion: characteristics of states in which it exists and its impact on service users

Dr Sam Rowlands

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Abstract

Background

Spousal authorisation of abortion does not align with modern thinking on respect for autonomy. The World Health Organization guideline on abortion specifically recommends that abortion should be available on request without third-party authorisation.

Objectives

To determine which states insist by law on SA.

To describe the characteristics of these states.

To describe the impact of such legislation on access to abortion.

Method

Interrogation of known databases on global abortion laws.

A literature review of material on how mandatory SA relates to reproductive rights.

Results

Fifteen states were found to require SA for abortion. These include 10 which can be described as states with Islamic values and policies and two of predominantly Christian faith. Three South Eastern Asian states stand out from the rest as modern, progressive and without strong religious influence: Japan, South Korea and Taiwan. These three also have a high degree of freedom in terms of political rights and civil liberties, indicating that there is realistic scope for citizens to influence policymakers.

While human rights bodies have recognised that it may in principle be desirable for a decision to terminate a pregnancy be made in consultation with a spouse/partner, that decision must not be limited by spouses or other third parties. Broader studies on third-party authorisation for abortion

show delayed access to abortion and emphasise the general principle that it is the healthcare seeker alone whose consent is required for a health intervention. A qualitative study from Turkey showed specifically how SA requirements could impair access to abortion.

Conclusions

Deeply patriarchal societies will take generations to change. In contrast, Japan, South Korea and Taiwan would seem likely candidates for liberalisation of abortion law by elected representatives after advocacy campaigns by civil liberties and women's rights pressure groups.

P48

Introducing an online self-referral system to improve access to abortion care in Cardiff

Dr Priya Vansia, Dr Caroline Scherf

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Abstract

Background and Objective

Diminished resources and staff shortages during the Covid-19 pandemic meant people trying to access abortion care were waiting days for the phone to be answered and often being told the wrong information. Patients were anxious, time-critical appointments were delayed and there were numerous complaints. An online system was therefore needed to streamline self-referrals and provide patients with accurate and reliable information whilst awaiting their appointment.

Method

A Microsoft Form was developed for patients to securely input their demographics, pregnancy details and relevant medical/social history. This is available on the Cardiff health board website and via QR code. Once the form is completed the sender receives written information about the Cardiff abortion care service. This includes how long to expect to wait for an appointment, details about the methods of abortion care available and links to other recommended services (e.g. online STI testing). The patient details from the form are transferred via power-automate to Sharepoint, which is only accessible by our abortion care nurses and administration staff. A traffic-light system is used to prioritise those of higher gestation. Staff can see the date of referral and use demographics to immediately allocate an appointment via text message or phone call.

Results and conclusion

The main challenges with the project included relying on a clinician rather than IT staff to develop it, dissemination to GPs of the change in referral process, patients not accurately filling out data and training of staff with a new system. However, the system has been running for over a year now and staff can more efficiently manage the 50+ referrals a week. It also allows people accessing abortion care to self-refer at any time of day and immediately receive information about their local service and what they should do next.

P49

Challenging Coalitions: Navigating Abortion Advocacy in the Maltese Context

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Abstract

Background: The abortion rights movement in Malta is quite recent, gaining momentum in 2019 with the formation of the Voice for Choice coalition. Since then, various social justice organisations have joined the cause, including Malta's LGBT Rights Movement (MGRM). The movement has faced both progress and setbacks in the past five years. This presentation focuses on the initial findings from an ongoing study.

Objectives: The research project aims to explore abortion rights activism in Malta, its potential to activate legal change, and its relationship to other social movements.

Methods: A review of global abortion activism literature was conducted to identify contemporary strategies and discourses used by movements worldwide. A workshop with 6 abortion rights activists in Malta mapped the history and key junctures of the movement. In-depth interviews with 25 activists from diverse social justice movements explored motivations, strategies, challenges, and the complexities of coalition-building.

Results: Emerging findings reveal the emotional nature of abortion discourse in Malta, emphasising the need for more nuanced discussions and outreach. Initial themes reveal the importance of empathy and dialogue with those who do not adhere to a pro-choice stance. The research also identifies the challenges faced by other social justice movements in aligning with abortion rights activism due to stigma and potential repercussions. Additionally, it highlights the importance of intersectionality, ensuring that the voices of marginalised groups, such as women with disabilities, migrants, and LGBTQ+ individuals, are included in the movement.

Conclusions: Preliminary conclusions suggest that achieving meaningful change in abortion law and access requires a multi-faceted approach that addresses deeply-held societal values and resistance. The research suggests that promoting empathy, dialogue, and coalition-building, while also addressing the concerns of marginalised groups, can contribute to a more inclusive and effective movement for abortion rights in Malta, paving the way for legal and social change.

P50

"A big part of our society covers their mouth when they talk about abortion": why context matters when implementing digital solutions for sexual and reproductive health

Ms. Paula Pinzon Hernandez[1,2], Ms. Roppan Gill[1,3], Ms. Isabel Pérez[4], Ms. Frida Bolaños[5]

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Abstract

Background

Beliefs, cultural and legal context are still the biggest access barriers around the world. Activists and healthcare providers have had to create strategies to overcome those access barriers and ensure that people seeking abortion and post-abortion care can get safe and evidence-based solutions. Our analysis aims to share insights about the importance of analyzing the context when implementing human-centred design tech tools to contribute to access to medical abortion care, based on the experience of the digital medical abortion and contraception tool, Aya Contigo.

Objectives

To explore and analize the abortion context in Guatemala to effectively adapt and implement Aya Contigo.

Methods

We conducted 11 semi-structured interviews with key stakeholders in Guatemala and conducted a desk review based on results provided by Google Scholar, PubMed, and World of Science, and official reports of the country.

Results

"No one is willing to fight for abortion", one stakeholder told us. Guatemala's legal context is the first access barrier to safe abortion in the country. However, even though there are exceptions where abortion is decriminalized (when the pregnant person's health is at risk), people still avoid accessing safe abortion because of the negative cultural connotation of the procedure. There are important barriers of access to culturally appropriate sexual and reproductive health that prevent Indigenous communities from accessing timely and high-quality care.

Conclusion

Undergoing a contextual analysis has been a key learning as we adapt and implement Aya Contigo in different contexts, highlighting the need to understand the context to assist with integration of digital solutions within existing ecosystems. Developing a deep analysis of contexts allows us to take

into consideration the barriers and facilitators to the successful and effective implementation of Aya Contigo.

P51

Facilitating access to contraceptive care for people in precarious situations

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Unité de santé sexuelle et planning familial / Hôpitaux Universitaires de Genève, Geneva, Switzerland

Abstract

Background

In Switzerland, contraceptive care is subject to medical prescription and mainly prescribed by gynaecological specialists, whose access is saturated. A large migrant population without legal status resides in Geneva and have been shown to suffer from various barrier in accessing healthcare (financial, asecurological, language, social…). These migrant population is **2 to 3 times more affected by abortions.**

The Sexual Health Unit (SHU) of the University hospital Geneva (UHG) has low threshold access and is widely identified by migrant women. One hour consultation for contraception counselling with a sexual health specialist (DAS) is offered free of charge, but not for prescription.

Objectives

Facilitate access to contraceptive care for migrant people in precarious situation to prevent unwanted pregnancies and promote efficient use of the health system resources.

Method

1. Develop a medico-delegated prescription tool for the SHU and an orientation algorithm in the UHG.

2. Obtain authorization for a transfer of activity for contraception prescription

3. Train primary care physicians around contraception prescription and follow-up

4. Deploy the intervention (expected May 2024)

5. Evaluate the project in 4 axes:

A. Impact on time to access contraceptives and unintended pregnancies

B. Security of the process

C. User satisfaction

D. Acceptance of the process by SHU professionals

Results

Points 1. and 2. have been validated. Point 3 is ongoing in 2024.

Points 4 and 5 will be deployed in 2024 and 2025.

Conclusions

This ongoing project is an innovative response to a public health issue impacting an already vulnerable population. Its strength relies on the valorization of existing structures and competences and its wide support by all concerned Departments of UHG. We hope that evaluation will show an improve access to contraception care for migrant population while being safe and acceptable for everybody.

P52

Challenging abortion stigma: from research into practice.

Professor Lesley Hoggart[1], Associate Professor Jayne Kavanagh[2]

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Abstract

Background: this presentation draws on research findings to discuss ways in which abortion-related stigma may be challenged; and describe a new UK charity – *Abortion Talk* – launched in order to achieve this.

Methods: two bodies of research. The first comprises qualitative research studies on abortion experiences in the UK, selected for secondary data analysis on abortion-related stigma. The second is the Sexuality and Abortion Stigma Study (SASS) which re-examined data from a decade of studies on abortion in the UK.

This research has shown that abortion stigma can be experienced and internalised by people undergoing an abortion and by those providing an abortion. However, in both bodies of research there was evidence to suggest that many resisted this stigmatisation. Resistance and rejection narratives involved rethinking or challenging socio-cultural norms around reproduction and motherhood, and stigma management strategies were grounded on rejecting notions of blame and shame. The research shows that abortion-related stigma is influenced by social and cultural contexts, but is neither universal nor inevitable.

Sexual and reproductive health services are part of a social context that influences abortion-related stigma. Providers thus have a role to play in helping to normalise abortion and challenge abortion-related stigma. This research, combined with other studies, provides the rationale underpinning the development of the charity *Abortion Talk.*

Abortion Talk aims to encourage and facilitate conversations about abortion with individuals and communities in order to end stigma. It provides a safe space to talk for anyone affected by abortion, including, people who have had an abortion, are thinking about having an abortion, are supporting

someone who's having an abortion and healthcare providers. Abortion Talks two main activities are operating an evening Talkline which anyone affected by abortion can call; and workshops for healthcare providers and community groups.

P53

What kind of innovations in abortion care have been implemented in France, Germany and the UK following the COVID-19 pandemic?

Dr Celine Miani[1], Jana Niemann[2]

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Abstract

Aim of the study

Through an international comparison of health systems and policies, we aim at assessing the contextual and circumstantial characteristics of abortion care innovation in three European countries following the upheaval of the COVID-19 pandemic. The three contrasting care models pre-pandemic constitute an interesting baseline for observing different systems' reaction to health crises.

Method

We conducted a review of the recent (2020 onward) peer-reviewed and grey literature, including national policy documents and guidelines. We then carried a comparative analysis of innovations implemented during the pandemic and their sustainability post-crisis.

Results

In France and the UK, where abortion care was more accessible before the pandemic than in Germany, a series of innovations were officially introduced to facilitate access during the pandemic. They included teleconsultations and the mailing of abortion medication. Most changes have been sustained since then, contributing to addressing historic and systemic health inequities in terms of access (e.g. due to geography and the existence of "medical deserts"). In Germany, innovations during the pandemic have been crafted by the civil society through NGOs offering for the first time teleabortion services (e.g. Balance Berlin and Doctors for Choice). The legitimation of those practices by professional bodies is still in the making, highlighting the limitations of the catalyst role of crises in the face of cultural barriers and resistance of health systems to innovation.

Conclusion

The COVID-19 pandemic provoked or accelerated innovation in terms of abortion care in France, Germany and the UK. Yet, its sustainability, as well as its scaling up, remains fragile, especially in Germany, where the disruptive approach of civil society organisations has not yet found its way into mainstream health care services.

P54

Abortion Trajectory, Timing and Access Study (ATTAS)

Anna Wallays, Prof. Dr. Sarah Van de Velde

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Abstract

This study explores the trajectories of women presenting for abortion in Flanders, Belgium. It has two primary objectives. First, it maps the various stages of the abortion trajectory for women presenting for abortion. Second, barriers that cause delays within these stages are identified. Data were used from the ATTAS project, which collected data among all women seeking abortion care at one of the Flemish abortion centers; specifically, the LUNA centers. Preliminary results show that a considerable number of women experience difficulties suspecting an unplanned pregnancy. This can be due to various reasons such as not immediately linking the symptoms to a possible pregnancy, mistakenly believing it is hard or impossible to get pregnant in their particular situation. Additionally, over one-third of women who completed the questionnaire up to now first had a consultation with a GP before they contacted the abortion center, which lengthens and in some cases complicates the trajectory. We also found that around 40% of the respondents indicated feeling ashamed or disappointed in themselves when deciding about the pregnancy. However, 94% indicated that their decision was set at the time they completed the questionnaire. Around 46% experienced fear of the procedure and associated pain. Furthermore, qualitative data are currently being collected to gain an in-depth understanding of abortion trajectories. To our knowledge, this is the first study within the Flemish context to investigate abortion timing, access, and trajectories. Furthermore, this study is highly topical given the ongoing public and political debates on Belgian abortion legislation.

P55

Abortion advocacy models to increase access

Daile Kelleher

Churchill Fellow, Brisbane, Australia

Abstract

As a 2023 recipient of a Churchill Fellowship, in 2024 I will be visiting Mexico City, the USA (New York, Washington DC and Texas), Canada, Belgium, the Netherlands, France and New Zealand to investigate abortion advocacy models to influence government policy and increase access to abortion. I will be sharing initial findings in preparation for my research report being published after my Fellowship. I will discuss the state of access and advocacy in my home country, Australia and the similarities and differences of the countries I have visited. I will share recommendations for advocates to incorporate into their work.

Legal Aspects

P56

Abortion Laws: Why we still don't need any – even "good" ones

Ms. Joyce Arthur

Abortion Rights Coalition of Canada, Vancouver, Canada

Abstract

Canada has successfully had no abortion law for 36 years. The Supreme Court of Canada struck down the previous law in 1988 as unconstitutional because it violated women's bodily autonomy. Our experience has proven that no abortion law is needed, because the general practice of "as early as possible, as late as necessary" (with almost all abortions happening by 14 weeks) happens naturally and is driven by patient needs and doctor responsibility, independently of any legislation. Laws serve only to delay care, cause trauma and hardship, and offend human dignity.

After Roe v. Wade was overturned in the United States, the Canadian government suggested that abortion rights and access should be protected by law. But several reproductive rights groups in Canada disagreed. We argued that any such law could be amended or repealed, and in effect provide a tool to anti-choice forces by which to add restrictions or challenge the law. Legislators don't belong in doctors' offices, as this creates the risk of new barriers even if unintentional. Enshrining the right to abortion into Canada's constitution is also unnecessary because the right is already well protected legally. To improve access and reduce stigma, other means are available to the government such as enforcing the *Canada Heath Act* to ensure equitable access to abortion care in every province, providing dedicated funding for SRH, and officially refuting anti-choice misinformation.

Canada's lack of an abortion law is a proven strength – not a weakness. Other countries should look at Canada's experience and consider repealing their laws or not replacing those struck down by courts.

P57

Cybersecurity in FemTech: Protecting Users of Digital Abortion Tools in Restrictive Contexts

Dr. Anjali Sergeant[1], Ms. Lara Maria de Araújo Machado[2], Dr. Genevieve Tam[2], Ms. Isabel Pérez[2], Dr. Roopan Gill[2,3]

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Abstract

Background

Globally, the sexual and reproductive health (SRH) of millions of women and girls is under threat from repressive political regimes and legislation. Digital SRH tools can offer critical and life-saving resources in restrictive contexts, but user data risks being breached by third parties for surveillance or retributive purposes.

Objectives

With the goal to protect all users, this abstract will evaluate the cybersecurity and safeguarding considerations for a digital medical abortion and contraception tool, Aya Contigo, in Venezuela and the United States.

Method

We present a descriptive commentary and evaluation of the cybersecurity considerations for Aya Contigo. The cybersecurity protocols for the digital intervention were created with a user-centred design approach and input from cybersecurity experts.

Result

To maximize user privacy and security, Aya users are provided with a privacy statement that includes information on managing data stored on personal devices. The application features an inconspicuous icon that optionally includes PIN-based password protection, an end-to-end encrypted chat with real-time support within the app itself, and a one-step mechanism to delete all app-related data. The application's securitized back-end stores limited user data and does not collect any personally identifiable user information.

Conclusion

In order to offer safe and effective digital tools for SRH, organizations must focus on safeguarding user data and exercise transparency about the risks of digital tools. Aya Contigo is an example of a digital abortion app that offers security through both its user privacy features and back-end data policies. In a digital space where regulation is often sparse, SRH-focused resources must include a robust and adaptable cybersecurity strategy to best protect users.

P58

Barriers to and potentials of abortion care on demand in Germany: Results of a qualitative interview study with gynaecologists and counsellors.

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Charité, Institute for Ethics in Medicine and History of Medicine, Berlin, Germany

Abstract

Objective: In Germany abortion is regulated within the Criminal Code. Abortion on demand is considered immoral and a criminal offence by the State. Patients will not be prosecuted though if they undergo a mandatory counselling and a three day-waiting period. To date the German healthcare structures for abortions has been insufficiently investigated. Available data indicate large regional differences in terms of availability, access to and quality of treatment. The aim of this study was to identify the causes of these differences and to develop potential possibilities for improvement.

Material and methods: Between 9/2020 and 5/2021, 42 semi-structured expert interviews were conducted with gynaecologists and abortion counsellors nationwide. The data were analysed using qualitative content analysis according to Mayring.

Results: In the interviews, the availability, accessibility, acceptability and treatment quality of abortion care were described as regionally disparate, with a north-south and urban-rural divide. Identified causes were a shortage of doctors who perform abortions and a lack of education and training. Further barriers to access are a lack of information transparency and the legal requirements for counselling according to German law. Existing barriers are further exacerbated by language barriers and misinformation or disinformation. The experts emphasized that the stigmatization of the intervention associated with criminalization limited the accessibility and acceptability of existing care structures. Potential solutions included decriminalizing the procedure, addressing and destigmatizing it in education and training, as well as utilizing the potential of medication-based methods, digital care services and the recruitment of general practitioners.

Summary: The current legal regulation in the German Criminal Code and the stigmatization of the procedure lead to structural barriers in the provision of abortion care and make patient-centred care more difficult. A new regulation, currently debated in Germany, should aim at removing existing structural barriers and improving the working conditions for personnel.

P59

Efectos de la despenalización del aborto en Colombia

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Abstract

On February 21, 2022 Colombia witnessed a milestone regarding decriminalization of Voluntary Interruption of Pregnancy (IVE) placing the country as a reference in guaranteeing sexual and reproductive rights of girls, adolescents and women through the issuance of Ruling C-055, this legal decision expanded the right to abortion by allowing women to interrupt their pregnancy according to their own reasons without facing any penalization, during the first 24 weeks of gestation.

The objective of this research was to analyze how Ruling C-055 of 2022 has affected access to safe abortion services. A face-to-face survey was applied to users of Profamilia's IVE services in Bogotá, Medellín and Barranquilla, a nationwide virtual survey for women, semi-structured interviews with women who had undergone the IVE procedure in Profamilia's clinics in each of the prioritized cities, and a survival analysis to explore the temporal relationship between the diagnosis of pregnancy and the performance of IVE's in Profamilia's clinics.

One of the most significant findings of this analysis is the trend in the cumulative survival probability in relation to gestation time “survival ratio”. According to the indicator created to measure the Expected Gestational Age (EGE) at which the abortion is performed, significant changes are evident in the dynamics inherent to the period in which the termination takes place, since each procedure is associated with a different gestational age.

It is essential to promote campaigns to raise awareness about the legality of abortion. Beyond understanding the legislation, it is essential to disseminate the fact that the procedure is not penalized and is accessible through the general health and social security system.

There is a lack of perception of safety in many women, both before and after the procedure. It is crucial to improve accompaniment and information during and after the procedure

Medical Abortion

P60

Effectiveness of Very Early Medical Abortion – retrospective data analysis in a Dutch abortion clinic

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Abstract

Background:

Most women recognize their pregnancy very early, often immediately after a missed period or even before. They typically decide within a few days if the pregnancy is unwanted and seek to terminate it as soon as possible. Medical treatment and b-hCG testing (blood or urine) enable very early medical abortion (VEMA), which occur before pregnancy location can be confirmed by ultrasound. VEMA may reduce pain and bleeding and facilitate early detection and treatment of ectopic pregnancies. Measuring b-hCG levels before and after medical abortion effectively confirms successful abortion and detects ongoing or ectopic pregnancies. Unfortunately, concerns about VEMA's effectiveness and the risk of ectopic pregnancy have led to inconsistent protocols and delays, highlighting the need for more research to establish evidence-based guidelines.

Methods:

We performed a retrospective cohort study of 1,018 women seeking abortion at the Dutch Vrouwen Medisch Centrum (VMC), from December 2023 until April 2024. VEMA was defined as gestational age below 5 weeks. Ten patients were excluded from the analysis (8 not pregnant, 2 ectopic pregnancies). Medical abortion consisted of 200 mg mifepristone followed by 800 µg misoprostol 36-48 hours later.

Results:

From the total women seeking abortion, approx. 25% were VEMA patients (n=253), of which 243 VEMA patients received medical treatment. When the medical protocol was applied, 93.8% of cases (n=228) resulted in a complete abortion. When successful, the average decrease from baseline b-hCG levels was 92,4 ± 9,1%, while unsuccessful cases (6.2%, n=15) showed an increase in b-hCG levels.

Conclusions:

VEMA is effective for early pregnancy termination, and measuring b-hCG levels reliably confirms success and detects ongoing or ectopic pregnancies. Therefore, VEMA should be offered to women as soon as they decide to terminate their pregnancy.

P61

Acceptability of Early Medical Abortions in relation to Ultrasound Certainty of Pregnancy Localization

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Abstract

Objective:

To determine if acceptability of early medical abortion differs between pregnancies of unknown location (PUL) and probable intra-uterine pregnancies (pIUP) versus confirmed intrauterine pregnancies (cIUP).

Methods:

This is a secondary analysis of the VEMA-trial on early medical abortion with randomization to either immediate abortion before confirmed pregnancy location, or delayed care post-confirmation. The present study includes patients with known abortion outcomes of complete abortion, incomplete abortion, or ongoing pregnancy. Ultrasound classifications of pregnancy location were PUL (empty uterus), pIUP (intrauterine sac without yolk sac), and cIUP (gestational sac with at least a yolk sac). Acceptability was measured as satisfaction on a 0–6 scale with higher values for higher satisfaction, pain severity on NRS 0–10 scale with higher values for more pain, and bleeding duration in days, with cIUP as reference group.

Results:

A total of 1292 patients were included: 18% (224 patients) with PUL at abortion, 37% (476 patients) with pIUP, and 45% (577 patients) with cIUP. Satisfaction scores were significantly higher in PUL and pIUP pregnancies compared to cIUP, with a mean of 5.5 (SD ±0.9) in PUL, 5.7 (±0.7) in pIUP and 5.4 (±1) in cIUP ($p = 0.01$ for PUL vs cIUP comparison and $p<0.001$ for pIUP vs cIUP comparisons). Mean NRS for pain was 5.2 (±2.3) in PUL, 5.4 (±2.3) in pIUP and 5.8 (±2.4) in cIUP ($p<0.01$ for both comparisons). Bleeding duration averaged at 4.9 days (±3.2) in PUL and 5.8 days (±3.2) in pIUP, as compared to 7.0 days (±5.2) for cIUP ($p < 0.001$ for both comparisons).

Conclusion:

Immediate abortion care before confirmed intrauterine pregnancy was associated with greater satisfaction, reduced pain, and shorter bleeding duration compared to delayed abortion post-confirmation. The difference was statistically significant for both PUL and pIUP, thus supporting early medical abortion intervention.

P62

Implementing medical abortion through telemedicine in Colombia: a qualitative study

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Abstract

Background: The non-governmental organisation Profamilia developed and implemented medical abortion through telemedicine in response to the Covid-19 pandemic. This service is now integrated as an alternative to in-person care and available to abortion-seekers across Colombia. Previous research has emphasised bottlenecks in abortion provision, but less is known about implementation processes and experiences.

Objective: To assess the feasibility and acceptability of telemedicine for medical abortion from the perspectives of key informants involved in the implementation in Colombia.

Methods: We conducted 15 in-depth interviews with healthcare professionals, coordinators and support staff implementing telemedicine for medical abortion in the early phase of implementation, between March and October 2021. We analysed the data using the framework method and applied the normalisation process theory in our analysis and interpretation of findings.

Results: Our findings show that strong leadership, organisational efforts on pre-implementation training, monitoring and evaluation, and collaboration between diversely skilled and experienced providers are essential for successful implementation. Participants were generally positive towards the use of telemedicine for medical abortion; concerns related to effectiveness, safety and safeguarding existed mainly among providers with less clinical experience. We identified contextual barriers, such as social opposition, regulatory barriers, providers' unavailability, and poor phone and internet connections in rural areas, which impacted the feasibility of the intervention negatively.

Conclusion: In conclusion, to ensure stakeholders' buy-in and for the service to reach all abortion seekers in need, future implementation endeavours must address concerns about safety and effectiveness, and tackle identified contexual barriers.

P63

PAIN THERAPY ON REQUEST FOR MEDICAL ABORTION IN DAY-HOSPITAL. ONLY ONE THIRD ASKS FOR PAINKILLER.

Dr Silvio Viale

Sant'Anna Hospital, Turin, Italy

Abstract

We compared the request of women for painkillers in two sequential groups. The first group with the administration of two doses of 400 mcg of misoprostol three hours apart orally and the second group with the single administration of 800 mcg orally. Both groups had received 600 mg of mifepristone two days before. Women return home after mifepristone and remain in the hospital on the day of misoprostol administration. Women on request may receive paracetamol 1000 mg IV or ketorolac trometamol 30 mg IM or IV.

Since the introduction of mifepristone in 2010 we have performed 20,299 medical procedures for abortions and missed abortions, observing that only a third of women require pain medication. For organizational reasons we wanted to see how the demand for painkillers would change with a single administration of 800 mg, comparing two sequential groups of women. Due to an oversight the second group was double the size of the first. Both groups include abortions and missed abortions.

The first group (400+ 400 mcg) includes 234 women, 189 abortions (80.8%) and 45 missed abortions (19.2%). The second group (800 mcg) includes 396 women, 310 abortions (78,3%) and 86 missed abortions (21,7%). The demand for painkillers was 89 women in the first group (38.0%) and 123 women in the second group (31.0%). Dividing the second group sequentially by two we have 200 and 196 women with 60 and 63 requests for painkillers, respectively, 30.0% and 32.1%, resulting equivalent.

The conclusion is that a single administration of 800 mcg reduces the need for painkillers from 38% to 31% and the explanation could be that each administration may cause more pain due to the administration itself. We have observed that more than two-thirds of women can manage medical abortion without need for painkillers.

P64

Early medical abortion before the missed period: a prospective observational study.

Miss Elizabeth Wheate

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Abstract

Introduction:

Introduced in 2017, Very Early Medical Abortion (VEMA) has become a crucial component of abortion services throughout the UK. This study sought to investigate various FSRH Vision Goals, examining potential impacts of socio-economic disparities on outcomes in unplanned pregnancy care, and assessing equitable access to comprehensive abortion services among these patients. This involved analysing outcomes for patients treated under four weeks of gestation and their clinical pathways, followed by comparing results based on patients' baseline characteristics.

Methodology:

A retrospective database review from March 2020 to December 2023 identified eligible patients seeking VEMA treatment. The search covered records of VEMA treatment outcomes alongside other clinical data entries.

Results:

During the 34-month data span, the database identified 82 patients who sought VEMA at less than 4 weeks gestation. This was determined using Last Menstrual Period (LMP), ultrasound scan (USS), or a combination of both techniques.

Within this cohort, 67/82 patients (82%) received VEMA treatment. Of these, 62/67 (93%) treatments were successful, and 5/67 (7%) VEMA treatments failed, requiring further intervention.

The 15/82 (18%) of patients who did not undergo VEMA due to the following: 4/15 (27%) miscarried, 2/15 (13%) decided to continue with pregnancy, 2/15 (13%) had ectopic pregnancies, 6/15 (40%) were not pregnant, and the outcome of 1/15 (7%) patient remains unknown.

Conclusion:

The preliminary data indicates that Very Early Medical Abortion (VEMA) is highly efficacious and should be offered to individuals seeking abortions under 4 weeks gestation.

P65

Medical abortion in the first and second trimester of pregnancy in North Macedonia

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Abstract

Background: Medical termination of pregnancy was implemented in clinical practice for the first time in the Republic of North Macedonia in 2020 as a safe, effective and reliable method for abortion.

Objectives: To evaluate effectivenes and safety of medical abortion in the first and second trimester of pregnancy and patient's satisfaction from method.

Material: In a retrospective study, we analyzed data from medical documentations for the efficacy, safety, and patient satisfaction of medical abortion in patients from the first and second trimester of pregnancy at the University Clinic for Gynecology and Obstetrics in Skopje in the period from 2020 to 2024. In investigated period medical abortion was made in 1808 patients (1437 patient's in the first trimester and 371 patient's in the second trimester of pregnancy). Combination of 200 mg Myfepristone orally and 800 µgr Misoprostol after 48 hours (400 µgr vaginally and 400µgr sublingually) was used. Often, after expulsion of fetus, additional doses of 400 µgr misoprostol sublingually were given in patient's in second trimester of pregnancy.

Results: Effectiveness of medical abortion was about 92% and patients satisfaction was more than 90% in both groups. A small number of serious complications were recorded (heavy bleeding with blood transfusion was recorded in less than 1% of patients). Other complications of medical abortion (fever, allergic reactions, diarrhoea) were reported in only several cases. Intense abdominal pain and cramping were treated with administration of ibuprofen, paracetamol and tramadol..

Conclusions: Results from our study showed that medical abortion in the first and second trimester of pregnancy is a safe and effective method for termination of pregnancy. Our results showed clear satisfaction from the newly-implemented procedure and acceptance by the patients as well as by health providers.

Key words: medical abortion, first and second trimester of pregnancy

P66

"Effectiveness and Acceptance of Self-Examination with a Low-Sensitivity Pregnancy Test after Medical Pregnancy Termination: A Partially Randomized Patient Preference Study in Germany"

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Abstract

Objective: To evaluate the efficacy, acceptability and patient satisfaction of self-testing using a low-sensitivity pregnancy test after medical termination of pregnancy (mSAB) in comparison with sonographic monitoring.
Materials: Women requesting medical termination of pregnancy in selected German practices will be included in the study after informed consent. The control examination will be performed either as a self-examination using a low-sensitivity pregnancy test or sonographically, in each case 14 days after medical abortion.
Methods: This study implements a partially randomised patient preference design (RPPT). The aim is to recruit 128 patients for the randomised study arm. In addition, patients who express a clear preference for one of the two control methods will be recruited outside of randomisation and form a separate preference cohort. The data collection covers the preferred or assigned control method, demographic characteristics, the success of the abortion and any complications that occurred. In addition, the patients' satisfaction with their chosen control method is recorded using a specifically developed questionnaire.
Results: Data collection is still ongoing; a complete analysis is pending. Insights into the effectiveness and acceptance of self-monitoring are expected. Initial trends show a positive response to self-examination. Detailed results, including preferences and medical outcomes, are planned for July 2024 and could lead to practice-relevant recommendations.
Summary: This study addresses the evidence gap regarding self-examination after medical abortion. It investigates whether self-examination can be an effective and accepted alternative to sonographic monitoring. Positive results could optimise follow-up practice and conserve resources. There is currently a lack of specific data in Germany, which emphasises the importance of the study.

P67

Contragestion, Mifepristone : Build Back Better

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Abstract

Are medical statements performative discourses that reproduce gender inequality and stereotypes?

Knowledge about birth control lies at the interface of scientific and religious representations, with gender issues as a common denominator.

Aims: highlight the presence of a cognitive bias in woman's reproductive health.

In reproductive health, the word abortion refers to the expulsion of a non-viable fetus, so when a woman seeks help to terminate her unwanted pregnancy, but there is no fetus yet, in early pregnancy, why do we use the word abortion?

The word abortion is still used to describe both an action taken on an early pregnancy, sometimes without identifiable embryo and on a 20-week-old fetus, which are very different things in terms of medical, surgical, hemorrhagic, or anesthetic risk. Are we dealing here with an ***obstetrical epistemicide***?

How is it possible to use the same word to refer to such different things?

Method

Literature review on PubMed since 1987 with the key word's abortion, miscarriage, contragestion.

Literature review in mainstream media about abortion, any date.

Results

According to scientific knowledge "fetal development begins from the ninth week after fertilization (or eleventh week gestational age)"

We found 50 relevant articles on PubMed.

According to one of those papers, 4 stages of birth control are identified.

- Contraception: is used to prevent fertilization,
- Contranidation: fertilization has occurred, but a therapeutic technique will prevent implantation,
- Contragestion: therapeutic technique is used to disrupt early pregnancy, when the fetus is not yet formed,

- Abortion, according to the definition of this word, a medical or a surgical procedure is used to remove a non-viable fetus, meaning a fetus before 20 weeks of pregnancy.

Conclusion: My proposal is a comprehensive three-stage model to reflect the dynamic of female birth control: contraception- contragestion- abortion, because Mifepristone procedure in early pregnancy is "neither contraception nor abortion".

P68

The embodied realities of self-managed EMA: What health professionals should consider

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Abstract

Background: Self-managed early medication abortion (EMA) has become an increasingly prevalent method of abortion worldwide. Self-management has advantages (including privacy, autonomy, availability of home comforts) and should thus be an available option. Nevertheless, numerous factors can negatively impact the lived experience of self-managed EMA, not least the embodied reality of what the process can entail. The pain element of EMA has recently received increasing attention. It is not pain alone, however, but a confluence of bodily experiences which can add up to an acutely unpleasant overall experience for those undergoing EMA.

Objectives: To examine accounts of the embodied experience of EMA in order to better understand the needs of, and inform development of resources to support, those self-managing EMA.

Methods: We conducted qualitative secondary analysis (QSA) on 135 interview transcripts from five research studies with women* in the UK who had undergone EMA, either self-managed or in-clinic, conducted from 2008-2021. A 'big qual' QSA approach - including focused thematic analysis - was used to identify key experiential factors.

Results: QSA highlighted a substantial body of data clustered around key elements of the embodied experiences of EMA – namely pain, heavy bleeding, vomiting, diarrhoea, and passing the pregnancy tissue – which, for some, converged to create an acutely unpleasant experience. For a sub-set of women, this meant that they would not wish to undergo medication abortion again, should the require a subsequent abortion.

Conclusions: Not everyone in our large qualitative sample described the embodied experience of EMA as being problematic or distressing, and the variability of unpleasant bodily experiences in EMA can make it challenging for services to get expectation-setting right. However, the significant body of qualitative data identified in this QSA highlights key issues which health professionals and services supporting those self-managing EMA should consider in order to provide effective patient-centered care.

P69

Reproductive surveillance and telemedicine abortion in Hungary

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Abstract

Hungary's approach to reproductive health is influenced by its demographic policies, which prioritize family support over sexual and reproductive health and rights. Affirming firm support to pursue pro-natalist policies, Prime Minister Viktor Orbán has declared that "the goal in 2024 is for families – rather than great struggles – to be at the centre of politics." In Hungary, abortion is legal up to 12 weeks when "the pregnant woman is in a severe crisis situation" and can be practiced after 12 weeks under specific circumstances. In 2022, the Hungarian government adopted a decree on the protection of fetal life, which requires medical practitioners to present pregnant women with a medical certificate demonstrating fetal vital functions in a clearly identifiable manner prior to an abortion. Following this decree, several politicians have argued, drawing on the official abortion statistics, that they managed to reduce the number of abortions.

This study puts this claim to the test by drawing upon an alternative data source, Women on Web. Women on Web is an online telemedicine abortion service established in 2005. While Women on Web data are not representative, they provide a rich resource and a counter-narrative to the current government discourse. Women on Web's services to Hungary were previously analyzed in 2017. Following up with this previous analysis, this study involves a retrospective analysis of Women on Web data from Hungary from 2018 to 2023. Our findings show that help requests received at Women on Web from Hungary grew consistently and significantly each year, from 101 requests in 2018 to 1,028 requests in 2023. We examined the demographics of care seekers, reasons for abortion, and motivations for seeking care via Women on Web.

P70

Making the case for reproductive choice- an information tool to guide the discussion about whether to have a medical or surgical

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Abstract

Introduction

Abortion is common: approximately 1 in 4 Australian women will have an abortion in their reproductive lifetime[1]. Women may have a choice between medical or surgical method. Studies reported women valued information on what to expect during and after the procedure and being informed what to expect when seeing the pregnancy tissue[2].

Methods

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) convened an expert group to develop an evidence-based Clinical Guideline for Abortion Care in Australia and New Zealand (2023)[2] with a companion resource to support discussions between clinicians and their clients[3]. Information needs prior to an abortion were informed by an existing NICE systematic review[4] outcome, and an updated literature search completed in May 2023. The Abortion Decision Aid[3] provides general information about abortion, a comparison table of surgical and medical methods, and a guide to determine the client's preferences. The Decision Aid was reviewed by the RANZCOG Consumer Network Working Group.

Guideline Recommendations

Choice:

Consider offering a choice of medical and surgical abortion up to 14 weeks pregnant, as both methods are safe, effective and acceptable.

From 14-24 weeks offer a choice of medical or surgical abortion as both methods are safe although medical abortion is associated with higher risk of incomplete abortion and may require surgical evacuation.

Information:

Women should be able to choose the method of abortion most acceptable to them, without coercion, informed by their values and preferences, after appropriate information is provided.

The guideline development group Good Practice Point recommends the use of a decision aid about abortion options.

Conclusion

RANZCOG's inaugural Clinical Guideline for Abortion Care and accompanying Decision Aid marks a significant advancement to standardising the provision of safe abortion services in Australia and New Zealand. Evaluation of the Decision Aid is recommended for future study.

Pain and Risk Management

P71

Prospective analysis of the association between perceived stigma and post-interventional pain during first-trimester abortion

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Abstract

Background In Germany 95.8% of abortions are performed within the scope of a consultation arrangement, which grants prosecution-free abortion within the first trimester if patients have undergone a process of mandatory counseling beforehand. There is currently a lack of studies investigating factors which might influence abortion-related pain perception.
Objectives The focus of this study is the analysis of association between individually perceived stigma and post-interventional pain. Because of the association between stigma and mental comorbidities, additional assessments of anxiety and depression are performed.
Methods The questionnaires used for this study include the ILAS Scale (Individual Level of Abortion Stigma), GAD-7 (Generalized Anxiety Disorder), and PHQ-9 (Patient Health Questionnaire). To measure pain, a NRS (numeric rating scale) from 0 to 10 is applied.
Results Our preliminary data-analysis includes 208 patients. 69 patients received a medical abortion, 66 a surgical abortion with local anesthesia, and 73 one with general anesthesia. The median patient age is 28.0 years with a median gestational age of 52 days of pregnancy. Based on the current data, the Pearson correlation coefficient between the ILAS score and the NRS score of the surgical abortion with local anesthesia is 0.09 ($p=0.46$), -0.05 ($p=0.80$) for general anesthesia, and 0.03 ($p=0.80$) for medical abortion. Furthermore, the correlation coefficient between the GAD-7 score and the ILAS-score is 0.39 ($p < 0.01$), similarly to the correlation coefficient between the PHQ-9 score and the ILAS-score of 0.41 ($p < 0.01$). The median NRS scores are 3 (IQR 3-5), 2 (IQR 0-4.25), and 7 (IQR 6-8.5) for surgical abortion with local anesthesia, with general anesthesia, and medical abortion respectively.
Conclusions Our results refute our initial hypothesis that there is an association between perceived abortion stigma and abortion-related pain perception. However, there is a significant association between depression and anxiety with perceived stigma. Further research is needed to confirm and characterize this preliminary observation.

P72

Pain management for medical abortions beyond 12 gestational weeks - experiences from a Swedish setting

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Abstract

Background: Medical abortion at later gestational ages is associated with high intensity of pain. Pain management for medical abortions > 12 gestational weeks (GW) is still debated.

Objectives: The primary outcome was to describe the pain intensity at predetermined time points. Secondary outcomes were to describe which analgesic options were used during the abortion and to compare their efficiency and the satisfaction of the pain treatment expressed by the participants.

Method: This trial was a descriptive cross-sectional study conducted at six centres in Sweden, including persons aged > 18 years with pregnancies of 85 - 135 gestational days. The participants swallowed mifepristone and returned to the clinic 24 – 48 hours later for the misoprostol treatment. NSAID and paracetamol were administered together with the first dose of misoprostol and repeated every eight hours. If required, opioids or PCB were offered. Pain was assessed using a visual analogue scale (VAS) and recorded at fetal expulsion, before additional analgesia was given and 30 minutes after. Before discharge the participants assessed maximal pain and satisfaction with pain treatment.

Results: We included 457 persons and after exclusion the final analyses set consisted of 425 individuals.

The participants estimated their maximum pain to a median of VAS 72 (0; 100) and at fetal expulsion to a median of 31 (0; 100).

In total 266 (63 %) participants administered an opioid orally, 86 (20 %) received an opioid parenterally and 163 (38 %) a PCB. The median change in VAS after administration was -20 for an opioid injection only, -39 together with PCB and -40 with PCB only. 91.1% were satisfied with the pain relief during the abortion.

Conclusion: Persons undergoing a medical abortion > 12 GW assess their maximum pain as severe, and the majority require additional analgesia. PCB offers efficient pain relief.

Second Trimester and More

P73

Comorbidities of Women Referred to a National Centre for Late Second Trimester Termination of Pregnancy (TOP)

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Abstract

Background

Late second trimester termination of pregnancies (TOP), defined here as TOP at or above 20 weeks gestation, contribute to the increased medical cost, maternal morbidity and mortality as compared to TOP at an earlier gestation. Evidence suggests that women seek later TOP for various reasons, such as difficulty recognising a pregnancy, relationship problems, young age, barriers to accessing TOP service and carrying fetus with anomaly.

Objective

To determine the comorbidities of women seeking TOP in the late second trimester in a national centre.

Method

During the period between January 2023 and May 2024, medical records of 104 consecutive pregnant patients with gestation 20 weeks and above, from the TOP clinic were reviewed in this retrospective descriptive study.

Results

Median age of these patients was 32 years (range 17-45); median parity was two (range 0-9). Out of the 104 patients, 46 (44%) has had previous TOP.

In this study group, 35.6% (37/104) had pre-existing mental health condition; 29.8% (31/104) were obese; 20.2% (21/104) had haematological condition, of which 14 were anaemia; 19.2% (20/104) had respiratory disease; 11.5% (12/104) had cardiovascular condition, of which nine were hypertension; 8.7% (9/104) had endocrine disorder, of which five were diabetes mellitus and four were thyroid disorder; 6.7% (7/104) had neurological condition; 5.8% (6/104) had gastrointestinal disease; 1.9% (2/104) had autoimmune disorder; 1.9% (2/104) had learning disability and 1% (1/104) had metabolic disorder.

Nine (8.7%) patients continued with pregnancy, 91 (87.5%) underwent surgical TOP and 4 (3.8%) medical TOP. Of those who completed TOP, 50.5% was given a long-acting reversible contraception (LARC).

Conclusion

More than 1 in 3 women who terminate their pregnancies at later gestations have pre-existing mental health conditions. This valuable finding helps service providers and policy makers understand the need of sexual and reproductive health support for women with mental health issues.

P74

Implementation model for second-trimester surgical abortions in Germany

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Abstract

Background

About 1200 women yearly travel from Germany to the Netherlands for an abortion, most of them after a gestational age of 14 weeks.[1] Under German criminal law abortions after 14 weeks of pregnancy are only possible with a medical indication. However, most hospitals that perform abortions in case of medical indications only offer medical abortions. Surgical abortions after 12 weeks of pregnancy are rarely to never offered in Germany.

Objectives

The aim of this project was to implement surgical abortions in the second trimester within hospital care in Germany. The research questions guiding this project were whether there is a demand for surgical abortions beyond 12 weeks of pregnancy in Germany and how this service can be integrated within the German healthcare system.

Method

From May 2023 until May 2024, all patients seeking abortion up to 24 weeks of pregnancy at Vivantes Klinikum Kaulsdorf (KHD) were offered a choice between a medical and a surgical abortion. In accordance with RCOG and NICE guidelines, a standard operating procedure (SOP) was established.

Results

A total of 71 patients between 12+0 and 24+0 weeks of pregnancy were treated at KHD. 62 patients opted for a surgical abortion, while medical abortions were performed in 9 cases. Through all cases, only one severe complication occurred.

Conclusion

The project has shown that there is a demand for surgical abortions in Germany beyond 12 weeks of pregnancy and that an implementation of this service within hospital structures is possible and necessary. Performing second-trimester surgical abortions at hospitals also gives junior doctors the opportunity to acquire these necessary skills during their education.

[1] Inspectie Gezondheidszorg en Jeugd (2023). Bijlage Jaarrapportage 2022 Wet afbreking zwangerschap (Wafz). Available at: Jaarrapportage Wet afbreking zwangerschap (Wafz) 2022 | Jaarverslag | Inspectie Gezondheidszorg en Jeugd (igj.nl)

P75

Expanding access to comprehensive abortion care through networks of private maternity hospitals in Ethiopia

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Abstract

Objective:

Ethiopia has one of the most liberal abortion environments in the region, however, six in ten abortions in Ethiopia are unsafe with only half (53%) performed in healthcare facilities. Access to second-trimester abortions in healthcare facilities is even more limited; only 10% of facilities have a healthcare provider who can perform this service. Maternity hospitals are uniquely positioned to expand access to comprehensive abortion care, and specifically 2nd trimester abortions, due to the availability of surgical infrastructure and the destigmatising nature of a facility offering a range of services.

Methods:

Routine Electronic Health Record (EHR) client data from Marie Stopes Ethiopia's (MSIE) maternity hospitals and core centres was analysed from January 2019 through December 2023. Data from MSI's latest annual, cross-section Client Exit Interview (CEI) surveys from 2018-2020 was also analysed to understand client experience and quality of care among clients who received an abortion or post-abortion care service. For both datasets, descriptive statistics and frequency tests were run using StataSE version 15.

Results:

In 2022 and 2023, there have been over 1.5x as many comprehensive abortion care client visits in MSIE's maternity hospitals compared to non-maternity centres. Among the maternity hospital clients, 23% of them accessed a SAC for >12 weeks compared to just 8% in all MSIE centres (maternities and out-patient SRH centres). CEI results show high client satisfaction with the service and that about two out of three (65%) clients report no other option for accessing this service.

Conclusions:

The data demonstrates that maternity hospitals can be genuinely positioned to increase access comprehensive abortion care as they possibly destigmatise the service while filling a major gap in access to surgical 2nd trimester abortions.

Statistics

P76

Lessons learned from mixed-methods monitoring and evaluation of a digital platform for accompaniment and harm-reduction for self-managed medical abortion

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Abstract

Background: Digital tools have become important means of supporting access to quality abortion care. Robust monitoring and evaluation (M&E) of these digital strategies is crucial to refine services, gauge impact, and better meet user needs. However, analyzing data can be challenging due to the importance of maintaining privacy and confidentiality. Employing innovative and creative methods is necessary to construct an evidence-based narrative while safeguarding users.

Objectives: This presentation aims to highlight lessons learned through Aya Contigo, a digital abortion companion in Venezuela and the United States.

Methods: A comprehensive review of past and current M&E processes was conducted to summarize best practices and future opportunities for improvement.

Results: Aya includes a mobile/web app, chat-based support, and local movement-building. Triangulation across these components allows for a comprehensive understanding of user behavior, impact, and areas needing improvement. Tools including Google Analytics 4 track app usage trends and user engagement. Pre-/post-tests from values clarification workshops provide insights into the local contexts affecting access to abortion care. Qualitative analysis of anonymized chat transcripts identifies opportunities to enhance the delivery of person-centered care. Additional methods, including UTM links and web traffic analysis, help understand user acquisition. M&E data from Aya Contigo has also been used to fit ARIMA models to project user volume and in linear regression to assess the impact of social media on reach. As of May 2024, Aya Contigo has reached over 7,000 app users and nearly 1,000 chat users in Venezuela and the United States. Robust M&E ensures that the reach of the platform continues to grow, especially among historically underserved populations.

Conclusion: M&E is fundamental in digital health interventions, and Aya Contigo illustrates the successful use of varied, novel methods to inform data-driven decision-making despite the challenges in conventional data analysis approaches.

Surgical Abortion

P77

Induced abortion in France between 14 and 16 weeks : Clinical context and complications

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Abstract

This is the first study in France to characterize the women's health care pathway and to evaluate the rate of complications during a surgical abortion according to the technique of dilatation and evacuation between 14 and 16 weeks since the extension of the delay in 2020.

Method: Single-center prospective study at the Armand Trousseau Hospital with inclusion of women who had an abortion between 14 and 16 GA in the Obstetrics & Gynecology Department of the ArmandTrousseau Hospital between March 2 and October 31, 2022.

Results : Forty-six women underwent an abortion during this 8-month period. The average gestational age at which the abortions were performed was 15 weeks' gestation with an median delay of 14.0 days between the date of discovery of the pregnancy and the date of the abortion with more than half of the women (65.2 %, N = 30) having consulted for the first time for an abortion request before 14 weeks' gestation. Of these women, 22 (48.9%) had to consult several hospitals before being treated. One woman (2.2% 95% CI [0.0–6.4]) had a haemorrhage defined by bleeding more than 500 ml. Cervical suture for cervicaltear was performed in four women (8.7% 95% CI [0.0–16.8]). There were no complications such as perforation, postoperative infection or surgical revision. No women were transfused.

Conclusion. – The introduction in our center of surgical abortion using the dilatation and evacuation technique performed between 14 and 16 weeks' gestation wasn't accompanied by significant morbidity.The women's pathway before the procedure probably contributed to the later performance of the abortion.

P78

Adolescents' experiences and care trajectories accessing abortion services in New South Wales, Australia: qualitative case-studies

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Abstract

Background

All women, including adolescent girls, have the right to equitable access to comprehensive abortion services and to being treated with dignity and respect. Despite an overall downward trend in incidence, abortion is still a common outcome of adolescent pregnancy in high-income countries. While adolescents face similar barriers to older women when accessing an abortion service, they experience additional legal barriers, concerns about confidentiality, longer delays, and greater cost and distance to services. Limited research has examined the experiences of abortion services from the adolescents' perspective which includes navigation of access and provision of adolescent-friendly abortion services

Objective

We sought to explore how adolescents (16-19 years) navigate this complex landscape in the Australian state of New South Wales (NSW) and explore the experiences and care trajectories of adolescents who had sought a first-trimester induced abortion

Methods

In-depth semi-structured interviews were conducted with adolescents and young adult females aged 16-24 years who had accessed an abortion service in NSW between the ages of 16 and 19 within the previous five years. Grounded theory and constant comparison method were used to analyse the transcripts.

Results

Four adolescent women aged between 18-24 who had accessed an abortion when they were aged 16-19 participated. The overarching meta-theme was 'The abortion trajectory is a profound personal crisis for adolescents'. Four themes were: (1) Trajectory of a personal crisis; (2) Building agency and taking control; (3) Isolation and (4) "Just getting people through".

Conclusions

Adolescents' needs are unique and have long been overlooked. Despite reported improvements in health literacy flexible, adaptive, and empathetic adolescent-friendly services are required. Acknowledging and addressing adolescents' needs through tailored information and support can enhance adolescent access to and satisfaction of abortion care in NSW.

P79

From contraception to specialist surgical care: What does "Reproductive choice" mean in 2024?

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Abstract

In England and Wales, the abortion rate is rising to unprecedented levels. 200,000 women a year access abortion and 13% have surgical procedures. Around 3,000 a year require specialist input due to health issues including diabetes, epilepsy, and heart problems.

Escalating living costs and contraception access challenges across England are key drivers behind the rising rate, along with demographic trends towards having fewer children. What does choice mean in this context? How do structures within healthcare systems restrict and support choice, as per recent research (Footman, 2022)? How do clinicians ensure we prioritise choice within a sustainable, publicly funded healthcare system at a time of economic prudence?

The authors explore links between access to contraceptive choice and rising abortion demand, including how upskilling a new generation of abortion doctors in England is a key component of ensuring sustainability. MSI Reproductive Choices (MSI) is a leading abortion provider in England, commissioned to provide for National Health Service (NHS) patients. Before MSI established a training programme for surgical abortion skills in 2021, there were approximately 20 specialist surgical abortion doctors covering the whole of England. Over half of the experienced surgeons were over 55 years of age and nearing retirement. Since the implementation of the training programme, 10 new doctors have acquired this important skill with more trainees scheduled to commence training. The authors share the successes and challenges of training provision in the independent sector and examples of NHS partnership working.

Women's choices need to be met with support, regardless of which point in their journey they access services. Women are struggling to access contraception, stigmatised when choosing abortion, and all too often denied choice of abortion method. The authors will share learnings and recommendations, such as including abortion in the core medical curriculum, and removing abortion from criminal law.

Unsafe or Safe Abortions

P80

Expanding Safe Abortion Access: The safe2choose Chatbot and Counselor Synergy

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Abstract

Technological advancements and expanded internet access have spurred the trend toward self-care in abortion services. safe2choose.org offers a digital counseling and referral model designed to meet diverse user needs, either seeking self-managed medical abortions or facility-based care. This person-centred approach is delivered by an international team of counsellors, supported by a chatbot accessible through secure live chat on the website and via email.

To overcome limitations in counselor availability and enhance service delivery, safe2choose introduced an integrated chatbot system to provide immediate information and support. This research evaluates the chatbot's effectiveness in delivering safe abortion care information, examining its handling of user interactions and in reducing human intervention.

The chatbot was rolled out in multiple phases: the English version in November 2023, the Spanish, Portuguese, and French versions in February 2024. Data were collected on user interactions, specifically examining the ratio of autonomously resolved conversations to those transferred to counselors, comparing performance and usage patterns.

Since its inception, the chatbot handled over 37,000 conversations. Initially, the English bot had a resolution rate of 20%. After launching Spanish, Portuguese, and French versions and introducing new automations, the resolution rate increased by 156%. As of May 2024, it autonomously resolves 52% of inquiries, transferring 48% to human counselors. These findings highlight the chatbot's efficiency in managing interactions, streamlining counseling, and enhancing overall service. By handling routine inquiries, the chatbot allows counselors to focus on complex cases, effectively combining automated and personalized services.

The chatbot system enhances abortion care counseling by autonomously managing a significant portion of user interactions across multiple languages. This collaborative approach underscores the value of counselors while demonstrating the advantages of integrating automated solutions with personalized care. However, continuously measuring and evaluating the system is crucial, as enhancements and new automations positively affect the resolution rate.

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Inequidades en el acceso potencial y real al aborto en Colombia, una mirada multidimensional

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Abstract

Voluntary termination of pregnancy (VTP) is a fundamental right of women and girls in Colombia so it is necessary to ensure that health services related to VTP have timely care at all levels of complexity and throughout the national territory (MSPS, 2018). However, although access to care for safe abortion should be equitable the quality and timeliness of care should not vary based on gender, race, religion, ethnicity, socioeconomic status, education, disability status, or geographic location.

To identify the areas of Colombia where the population does not have adequate access to abortion services, an evaluation of barriers to the implementation of clinical practice guidelines on abortion issued by the Ministry of Health and Social Security was proposed to health care providers, and based on this evaluation, an index of barriers to abortion was constructed from the supply of the service, which contributes to the study of inequities in the supply of services in Colombia.

The method is a mixed descriptive study, the measurement is based on three dimensions in the framework of international human rights mechanisms that identified four essential and interrelated standards for health services and the DSDR: Availability, Accessibility, Acceptability, and Quality, known as the AAAQ framework. Based on the instrument's performance, the weighting of the dimensions for constructing the index was calculated and the results were crossed with available demand indicators such as the abortion rate per 1000 population to determine the deficit produced by supply-side barriers. The result was an index of barriers to abortion from the supply side of the service.

P82

Young people's experience with abortion services in Nepal

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Abstract

Background: Abortion has been conditionally legalized in Nepal since 2002 and the country has made striking progress in rolling out induced abortion services. However, unsafe abortion still remains a major health concern.

Objective: To document the experiences of young people in regards to abortion from three representative districts of Nepal: Mugu, Sindhuli and Sunsari.

Method: This study used a descriptive cross sectional study design focusing on qualitative approach to capture the lived experiences, behaviours and perception of young women on abortion. Young women (18-35 years) who had experienced induced abortions were the major study population. Focus Group Discussions with post-abortive women and Key Informant Interviews with service providers and observation of the service sites were concluded in all the three districts.

Results: The use of traditional methods of abortion services has declined drastically and behavior of the service provider has improved. Most importantly, young women were found to be able to open themselves up while discussing about abortion. However, there are several challenges that still exists. Family planning is the main reason for abortion services, which is further influenced by son or daughter preference and patriarchy. Multiple abortions is being done by a woman in very small span of time. Also, though the direct service costs are now waived by the government, there are indirect costs associated with it that takes up month for women to pay the loan. Due to lack of proper infrastructures, especially in rural areas, confidentiality of the women, and the quality of services have not been well maintained.

Conclusions: People have been able to notice improvement in the quality of abortion services in recent years, especially after legalization of abortion but there exist several challenges with regards to abortion stigma and myths, accessibility especially in rural areas, expansion of services, self-induced unsafe abortions etc.