



Royal College of
Obstetricians &
Gynaecologists

Coronavirus (COVID-19) infection and abortion care

Information for healthcare professionals

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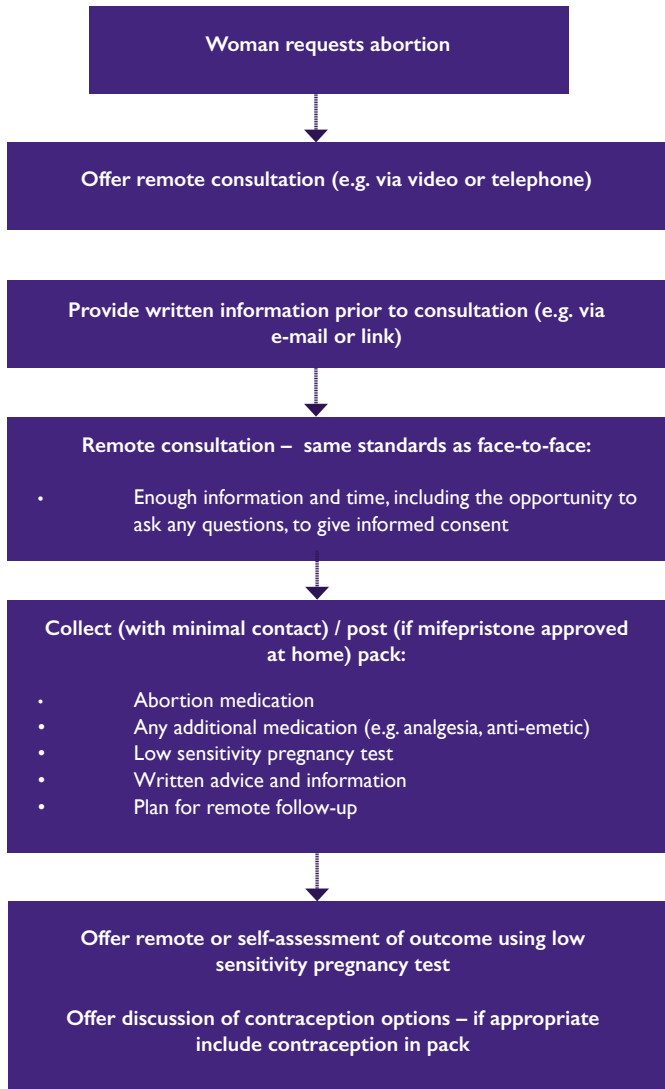
Table of contents

Chapter	Pages
Summary of updates	3
Flow chart: Summary of early medical abortion care management during COVID-19 pandemic	4
1. Introduction	5-8
2. Pathways to minimise COVID-19 exposure for women and staff	9-14
3. Abortion for women with suspected or confirmed COVID-19	15-18
4. Consent and safeguarding with remote consultations	19-20
5. Other pathways to manage resources and workload	21-22
6. Collaboration	23-25
7. Staffing issues	26-27
Acknowledgments and Referencing	28-31

Summary of updates

Version	Date	Summary of changes
2	31.3.20	1.3: Section updated to provide information on new regulations in England, Wales and Scotland permitting the home-use of mifepristone and misoprostol.
2	31.3.20	2.4: Additional information on when to provide a further dose of misoprostol for early medical abortion.
2	31.3.20	2.4: Additional information on pain relief options for early medical abortion.
2	31.3.20	3: New section added providing guidance for managing women with suspected or confirmed COVID-19.
2.1	9.4.20	1.3: New paragraph clarifying that two registered medical practitioners must still sign a form, agreeing that an abortion is to take place within the legal framework, but that this can be done remotely.

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



Abortion is essential health care

Services should be organised so as to minimise delays in care

Ultrasound only when necessary:

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

No need for routine blood testing

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

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

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

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

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

I. Introduction

Gender

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

I. Introduction

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

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

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

I.1 The virus

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

I.2 Guidance for people in the UK

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

1.3 Regulation of abortion care services

In England and Wales, abortion care is regulated by the Abortion Act 1967 which determines when and where an abortion can take place, and who can provide care. In Scotland abortion is also regulated by the Abortion Act 1967, but responsibility is now devolved to the Scottish Government. In Northern Ireland provision of abortion care is currently minimal, with most women travelling to England in order to access services. In Northern Ireland, a new legal framework was established on Tuesday 31 March 2020 made necessary by the Northern Ireland (Executive Formation etc) Act 2019.

The regulations around abortion care differ in each of the four nations. However, in England and Wales, the Department of Health and Social Care and the Welsh Government have both issued new and temporary regulations to permit the home use of mifepristone and misoprostol up until 10 weeks' gestation. These new regulations also permit medical practitioners to prescribe from home.

The Scottish Government has also issued new regulations which allow home use of mifepristone and misoprostol without defining a gestation. Where a gestational limit is not defined by law, healthcare professionals may judge when an early medical abortion at home is appropriate.

In England, Wales and Scotland, providers can offer a complete early medical abortion service with consultation taking place via video or teleconferencing, and a treatment package sent to the woman's home by courier or post. This will help to limit the spread of COVID-19 and allow women access to abortion care if they are self-isolating. Providers should now organise their services to adopt this new model of care.

In order to fulfil the statutory requirements of the Abortion Act 1967, an abortion must still be signed-off by two registered medical practitioners in England, Wales and Scotland. [Guidance from the Department of Health and Social Care \(2014\)](#) states that a registered medical practitioner can rely on the information obtained by other members of their team when certifying an abortion. This certification can therefore be performed remotely, including through use of an electronic signature.

In Northern Ireland, home use of mifepristone and misoprostol is not currently permitted. An early medical abortion service which could be provided by remote assessment and mail delivery of treatment would align with each governments' advice to limit social interaction and travel.

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

For more information on each of the legal and regulatory frameworks in your nation:

- [Temporary approval of home use for both stages of early medical abortion in England](#)
- [Temporary approval of home use for both stages of early medical abortion in Wales](#)
- [Temporary approval of home use for both stages of early medical abortion in Scotland](#)
- [A new legal framework for abortion services in Northern Ireland](#)

I.4 Priority

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

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

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

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

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

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

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

- Providers should organise early medical abortion services to be delivered via video or teleconferencing and delivery of a treatment package.
- Women who are self-isolating and suitable for an early medical abortion at home should be treated without the need for her to visit in person (e.g. by posting the required treatment pack) and without delay. At later gestations, providers should explore if assessment can be done as soon as possible in adequate isolation.
- Self-referral to abortion care is recommended by NICE and can be done remotely.
- Maximise the use of remote consultations (e.g. via video or telephone) to deliver pre- and post-abortion care and assessment.
- For women requesting an early medical abortion, only require her to attend in person where the benefit of doing so outweighs the risk of COVID-19 exposure and transmission.
- Provide abortion care without routine pre-procedure ultrasound.
- Provide abortion care without routine pre-procedure blood testing.
- If screening for sexually transmitted infections (STIs) is required, offer this remotely (e.g. via a web-based home testing service) when possible.
- Offer discussion of contraception options – if appropriate include contraception in pack.
- For medical abortion, provide a further dose of misoprostol 400 micrograms for use if abortion has not occurred after 3–4 hours, especially where gestation is likely to be over 8 weeks. If approval is given for 10–12 weeks in any nation, use 800 micrograms as either a single second dose or two further 400-microgram doses.
- Ensure the woman has adequate analgesia (e.g. ibuprofen) and offer additional analgesia (e.g. co-codamol 30/500 or codeine 30 milligrams) if requested.

Undertaking abortion assessments by phone or video call is recommended by NICE (1.1.9).⁷ Providing appropriate information governance safeguards are in place, a client may provide their medical and other

history using an online history form transmitted to the provider prior to the consultation.

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

2.1 Ultrasound scanning

Routine pre-abortion ultrasound scanning is unnecessary.⁸⁻¹⁰ Most women can determine the gestational age of their pregnancy with reasonable accuracy by last menstrual period (LMP) alone. A prospective trial of 4,484 women found that only 1.2% of women whose LMP dated them to less than 10 weeks had ultrasound dating of over 10 weeks.¹¹ The authors noted that even for this group, there is a high likelihood that treatment would be safe and effective.

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

Some providers use ultrasound to ensure the pregnancy is not ectopic in location. NICE guidance states that abortion can be performed without definitive evidence of an intrauterine pregnancy (1.7.1).⁷ In addition, routine screening of symptom-free women is associated with a high false positive rate when the prevalence of ectopic pregnancy is low, as is the case in the abortion-seeking population.¹²⁻¹⁴ A history and symptom-based approach, with an ultrasound if indicated, is consistent with NICE guidance on the diagnosis and management of miscarriage and ectopic pregnancy.¹⁵

A recent multicentre project tested the hypothesis that women with pregnancies at 8 weeks gestation or less can be safely provided with early medical abortion without a routine ultrasound.¹⁶ In total, 365 participants provided enough follow-up information for analysis, in which 95% (n=347) had complete abortion without additional treatment, 1% (n=3) required a surgical aspiration, and 1% (n=3) had a serious adverse event (2 hospital admissions for heavy bleeding managed with aspiration and 1 diagnosis of persistent gestational sac 19 days after enrolment) which were unlikely to have been prevented by conducting a pre-procedure ultrasound. Other studies have provided evidence that early medical abortion can be safely provided remotely up to 70 days' gestation and beyond.¹⁷⁻¹⁹

Reasons for undertaking an ultrasound before abortion in the first trimester include:^{7,8,20}

- I. If a woman is unable to provide a LMP of reasonable certainty to be able to offer care within

thresholds of eligibility or skill (e.g. 10 weeks for an early medical abortion under current regulations, 14 weeks for a vacuum aspiration).

2. History or symptoms suggestive of a high risk of an ectopic pregnancy, for example:
 - Presence of unilateral abdominal pain and vaginal bleeding / spotting which could indicate an ectopic pregnancy.⁸
 - An intra-uterine device in situ.
 - Prior ectopic pregnancy.
 - History of tubal damage or surgical sterilisation.

If a woman has already had an ultrasound, providers should accept the report from other services provided they meet standards of scanning for the UK²¹ and not repeat the scan unnecessarily. Ultrasound is not routinely required in the second trimester unless more accurate gestational age determination is needed to plan cervical preparation or other aspects of the procedure or to identify abnormal placentation in women with prior caesarean deliveries.

2.2 Blood testing

A robust pre-abortion assessment does not always need to include blood testing. Routine blood tests such as full blood count or testing for haemoglobinopathies are not recommended by NICE²² and should only be considered if there are specific clinical concerns. It is not cost-effective or necessary to 'group and save' for women undergoing induced abortion.⁹

Determination of rhesus status (RhD) is not required before early medical abortion (NICE 1.3.2).⁷ For surgical abortion, NICE guidance recommends this after 10 weeks but only to "consider" determining RhD status under 10 weeks (1.3.3). If having to check RhD status would require an additional visit for the woman, it could be omitted if the risk from COVID-19 outweighs the benefit of receiving anti-D immunoglobulin. If RhD testing would require additional contact in women up to 12+6 weeks of gestation requiring a surgical or medical abortion, the need to minimise contact to reduce the risk of COVID-19 transmission may outweigh any benefit from having anti-D. Providers should discuss the absence of evidence with women and engage in shared decision making.

Recent data from flow cytometry suggest that feto-maternal haemorrhage in early pregnancy is less than had been supposed, especially where sharp curettage is not used in surgical procedures. A small study found that of 42 women having a surgical uterine evacuation, none had levels of fetal cells sufficient to cause isoimmunisation.²³ The

NICE guidance on miscarriage states that anti-D is not required for medical management of missed miscarriage up to 13 completed weeks (13+6).¹⁵

The NICE abortion care guideline noted that assessment for anti-D should be individualised based on an individual woman's risk benefit profile and taking note of women's preferences⁷ (evidence review C). For example, anti-D is more likely to be beneficial in later gestations, in young women who are likely to desire pregnancies in the future, and where there would be no delay to their care by testing. In contrast, for same-day procedures where aspiration is used, especially at earlier gestations and where the woman considers her family complete, an assessment may conclude that anti-D is not warranted.

If a woman at any gestation is certain that she has completed childbearing and understands the risks of not receiving anti-D then there is no benefit in testing. Overall, should testing be considered necessary, clinicians should discuss the issues with the woman and weigh the risks of COVID-19 transmission, or delay to care that may result, against any benefits of checking her RhD status.

2.3 Sexually transmitted infection screening

If a screen for STIs is indicated²⁴ (or a chlamydia screen recommended as per the national screening programme best practice),²⁵ a web-based home testing service offers the best solution, although availability will vary owing to commissioning variations.

2.4 Early medical abortion

The regimens and process of medical abortion is set out in more detail in the NICE guideline and RCOG, FSRH and BSACP Clinical Guidelines for Early Medical Abortion at Home – England.^{7,26} Effective regimens for medical abortion include:

- Mifepristone 200 mg orally, followed 24–48 hours later by misoprostol 800 micrograms given by the vaginal, buccal or sublingual route.
- If abortion has not occurred, a further dose of misoprostol 400 micrograms after 3-4 hours can be administered.²⁷ If approval is given for 10–12 weeks in any nation, use 800 micrograms as either a single second dose or two further 400-microgram doses. Providers should consider supplying this to women at the outset.

Medical abortion is effective at all gestations, but additional doses of misoprostol are often needed to maintain high levels of success as gestational age advances (NICE 1.10.1).⁷ An observational study of 4,132 women having medical abortion up to 9 weeks' gestation found that the likelihood of complete abortion decreased

with increasing gestation ($p < 0.0001$).⁷ The addition of a second dose of 400 micrograms misoprostol if required reduced failure rates (odds ratio [OR] 5.88, 95% confidence interval [CI] 1.30–26.59) and removed the effect of gestation on success rates.

Given that it is especially important to reduce contact during the COVID-19 pandemic, providing a second dose of misoprostol for women to use 3–4 hours after the first if they have completed the abortion would seem prudent. If units do not have supplies of one additional dose of 400 micrograms and are unable to pack down their stocks of 800 micrograms, they should give two sets of 800 micrograms and instruct the women to use this for a second dose if required. Higher doses (either one of 800 micrograms or two of 400 micrograms) may be particularly beneficial after 10 weeks if home use approval is granted at these gestations.

Pain relief should always be offered and provided, if requested. There is evidence that NSAIDs (e.g. ibuprofen 400–800 milligrams) are effective for abortion-related pain, but also evidence that paracetamol is not. People are advised to use paracetamol in preference to ibuprofen for symptoms of confirmed or suspected COVID-19 but ibuprofen can continue to be used in other circumstances. Occasionally women may find the pain from medical abortion to be particularly distressing. Therefore providers should offer a stronger analgesic such as codeine or co-codamol 30/500 if the woman requests it, ideally in limited quantities. If the woman cannot obtain over-the-counter analgesia, for example because she is self-isolating or where supplies are not available in the shops, these should be provided in appropriate quantities.

Assessment of post-medical abortion outcome should be delivered with the use of a low sensitivity pregnancy test⁷ (NICE 1.14.2). Women should have the choice of self-assessment or remote assessment (for example telephone or text messaging) as an alternative to clinic follow-up⁷ (NICE 1.14.1). If low sensitivity pregnancy tests become unavailable, a high sensitivity pregnancy test may be used 3–4 weeks after treatment⁷.

Mifepristone and misoprostol are permitted for home-use in England and Wales up until 10 weeks' gestation and in Scotland without a gestational limit defined. For a home-use treatment package, providers should package the medicines needed (i.e. mifepristone, misoprostol, any analgesia or anti-emetic indicated), a low sensitivity pregnancy test (with instructions for use), written advice and a plan for follow-up or self-assessment. The treatment package could be sent by mail or courier. Where home use is not permitted, or if a woman would like to collect her treatment package, this should be done with minimal contact and from a reception area following assurance of identification.

Women should be given the option to discuss contraceptive options. Offer to include a method of contraception in the treatment pack (for example an oral contraceptive), especially when restrictions on travel and available services will impact on a woman's ability to access long acting reversible contraception.

**3. Abortion
for women
with suspected
or confirmed
COVID-19**

3. Consent and safeguarding with remote consultations

Staff should follow the latest national guidance from Public Health England (PHE) and locally agreed policies on infection prevention and control (IPC), including the appropriate use of personal protective equipment (PPE).

All women should be screened for symptoms of COVID-19 (a high temperature or a new, continuous cough) when presenting for abortion care. If she has symptoms, or has tested positive, a risk assessment should be undertaken to decide if abortion can be safely deferred for the isolation time recommended by PHE (persistent cough is not a significant factor in determining if she has recovered).

3.1 Self-isolation due to contact with suspected COVID-19

If the woman is suitable for an early medical abortion at home, this should be organised without the need for her to visit in person (e.g. by posting the required treatment pack) and without delay (see summary of early medical abortion care on page 2.)

Women who are self-isolating for 2 weeks due to household contact should be risk assessed for symptoms if face-to-face assessment is required. Care should be booked when the isolation period is over unless the gestation is uncertain, and the delay may result in a woman not being able to access abortion (e.g. owing to the pregnancy being over a legal threshold).

If the abortion cannot be deferred and face-to-face contact is necessary, request the woman to inform staff if she develops any new symptoms before her clinic appointment to allow for correct IPC measures to be taken, which may mean transfer to a unit that can treat patients with COVID-19.

3.2 Suspected / confirmed COVID-19

If the woman is suitable for an early medical abortion at home, she should be advised to take this approach if she has no or mild symptoms (persistent cough is acceptable), and before the pregnancy reaches 10 weeks' gestation.

If the abortion cannot be safely deferred and face-to-face contact is necessary, request the woman attend at a specific time (typically end of clinic, in a location that is equipped to manage COVID-19 patients) so correct IPC measures can be put in place. The woman should be given a surgical face mask to wear and asked to wash her hands on arrival.

If the woman requires face-to-face assessment but the pregnancy is likely to be under 20 weeks' gestation, care should be booked after at least 7 days since the illness started (unless she continues to be unwell, excluding a persistent cough).

If abortion cannot be safely deferred, assess whether the woman would be best managed with a medical or surgical abortion (e.g. if there are suitable facilities in an obstetric unit or gynaecology ward) in consultation with infectious disease, anaesthesia and infection control colleagues. If she is unwell, care should be co-ordinated through a multidisciplinary team.

If surgical abortion is performed:

- Perform vacuum aspiration under local anaesthesia or intravenous sedation where feasible to avoid need to need for general anaesthesia.
- Consider whether spinal anaesthesia or intravenous sedation would be more appropriate than an anaesthetic requiring ventilation.
- Consider checking full blood count, clotting and blood group if unwell.
- Ensure that best practice is followed to reduce risk of transmission of infection (e.g. limit number of people in theatre, use PPE and decontaminate area after procedure as recommended by PHE).

If the pregnancy is at risk of being over 23 weeks' gestation when the COVID-19 concern resolves (including time needed for cervical preparation):

- Admit and treat in facilities that can manage COVID-19 patients.
- Initiate medical or surgical treatment once afebrile.
- If either clinical condition prevents an abortion or the woman is approaching the legal limit, perform feticide and manage the abortion after her condition stabilises.
- For complex cases or later gestations, liaise as appropriate with specialist centres, fetal medicine units, anaesthetists, obstetric unit and infection control experts.

Current evidence, based on a small number of cases, suggests that COVID-19 is not present in genital fluid, although it is too early to know whether vertical transmission is a significant risk.³¹⁻³⁴

Unless the anaesthetic used involves ventilation, neither abortion nor obstetric procedures are classed as aerosol generating procedures which carry the highest risk of transmission of respiratory viruses.³⁰

In accordance with national guidance, recommended PPE for staff caring for women having an abortion with suspected or confirmed COVID-19 are disposable gloves, long-sleeved fluid repellent disposable gown, fluid resistant surgical mask and disposable eye protection.³⁰ Where the woman has no symptoms of COVID-19 or has a negative test, follow locally agreed PPE protocols.

For women who have symptoms of COVID-19 or confirmed infection, it is best to delay treatment until they have recovered and are no longer infectious where possible. However, if that delay would result in abortion becoming unobtainable owing to gestation, the abortion should proceed in a unit where appropriate IPC measures can be provided. The best method of abortion, whether medical or surgical, will depend on her clinical condition and the skills and facilities available.

Other considerations include:

- Anaesthesia that does not require airway management is likely to reduce the risk of transmission of infection.
- There are some case reports that clotting, bleeding and thrombosis may be deranged in severe COVID-19 infection (albeit not reported in gynaecology), and therefore pre-operative investigations may be prudent, with thromboprophylaxis considered post-operatively.
- If the woman's clinical condition prevents abortion, and she risks exceeding the gestation limit, feticide should be performed in collaboration with local fetal medicine services if necessary, to enable delay in the procedure to evacuate / empty the uterus.

4. Consent and safeguarding with remote consultations

4. Consent and safeguarding with remote consultations

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

The process of obtaining consent should follow normal best practice as detailed in GMC guidance.³⁵ This should include the information discussed; any specific requests by the woman; any written, visual or audio information given to the woman; and details of any decisions that were made. The consent must be recorded in the woman's medical records and include the key elements of the discussion with her, but it does not have to be on a specific form or signed by the woman – patients can give consent verbally.³⁵ Consent can be obtained remotely using telephone, internet or video link providing that it is appropriate to the woman and meets the same standards for content as would be undertaken in a face-to-face encounter.³⁶

The RCOG state in their guideline "Obtaining Valid Consent",³⁷

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

Safeguarding is an essential part of the assessment for abortion care, and providers should follow their processes and assess each case on an individual basis. However there is no automatic need to have to do this in person if adequate assessment is possible via remote consultation, although it is recommended that this should be tailored to the individual.³⁵ The clinician should be confident that the woman is not being coerced and that she is able to discuss any concerns privately.

**5. Other pathways
to manage
resources and
workload**

5. Other pathways to manage resources and workload

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

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

Nurses safely and effectively provide abortion care in many healthcare settings around the world and there is evidence that such care is preferred by women. Their role is supported by the NICE abortion care guideline (1.1.11).⁷

Surgical abortion can be safely delivered outside of an operating theatre, and without requiring anaesthetic support, by using effective local anaesthetic techniques (e.g. paracervical block),^{38,39} conscious sedation or intravenous sedation.^{7,40,41}

Medical abortion regimens using 200 mg oral mifepristone and misoprostol are effective and appropriate at any gestation.^{7,9} Many Trusts only offer medical abortion in the second trimester for termination in cases of fetal anomaly. However, if theatre capacity becomes increasingly restricted, services should consider retaining or expanding access to second trimester abortion services for all women.

Second trimester medical abortions can be completed as day cases when the interval between mifepristone and misoprostol is 36-48 hours (mean induction to abortion time of 6-8 hours).⁴² Feticide is recommended at 22 weeks (22+0) or greater;⁹ this should be facilitated collaboratively with fetal medicine services.

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

6. Collaboration

6. Collaboration

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

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

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

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

6.1 Considering transfer of care to independent sector providers

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

The contact details of the ISPs are:

BPAS

T: +44 (0) 3457 30 40 30 W: bpas.org

Marie Stopes UK

T: +44 (0) 345 300 8090 W: mariestopes.org.uk

NUPAS

T: +44 (0) 333 004 6666 W: nupas.co.uk

7. Staffing issues

7. Staffing issues

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

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

The prescribing of medication to procure an abortion is controlled by regulation in each UK nation. In England and Wales, the Government allow medical practitioners to prescribe from their own home for the purposes of early medical abortion.

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Additional resources

Support, advice and resources are also available from:

British Society of Abortion Care Providers (BSACP) – www.bsacp.org.uk

IPAS – www.ipas.org

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

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

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

Video consultation in abortion care – <https://bit.ly/2Qohd7b> (access code: GH207)

References

1. World Health Organisation. Safe abortion: technical and policy guidance for health systems. World Health Organisation. Second edition. 2012. Geneva, World Health Organisation. http://extranet.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1. Date accessed: 7-5-2018
2. Department of Health and Social Care. Abortion Statistics, England and Wales: 2018. 2019. London, Department of Health and Social Care. Summary information from the abortion notification forms returned to the Chief Medical Officers of England and Wales. <https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2018>. Date accessed: 1-7-2019
3. Stone, N. and Ingham, R. Who presents more than once? Repeat abortion among women in Britain. *J.Fam.Plann. Reprod Health Care* 2011;37:209-15.PM:21724621
4. Royal College of Obstetricians and Gynaecologists. Best practice in comprehensive abortion care. RCOG. 2015. London, Royal College of Obstetricians & Gynaecologists. Best Practice Paper No. 2. <https://www.rcog.org.uk/globalassets/documents/guidelines/best-practice-papers/best-practice-paper-2.pdf>. Date accessed: 1-10-2018
5. Bartlett, L. A., Berg, C. J., Shulman, H. B., Zane, S. B., Green, C. A., Whitehead, S., and Atrash, H. K. Risk factors for legal induced abortion-related mortality in the United States. *Obstet.Gynecol.* 2004;103:729-37.PM:15051566
6. Sedgh, G., Bearak, J., Singh, S., Bankole, A., Popinchalk, A., Ganatra, B., Rossier, C., Gerdts, C., Tuncalp, O., Johnson, B. R., Jr., Johnston, H. B., and Alkema, L. Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends. *Lancet* 2016;388:258-67.PM:27179755
7. NICE. Abortion Care. National Institute for Health and Care Excellence (NICE). NG140. 25-9-2019. London, NICE. NICE Guideline. www.nice.org.uk/guidance/ng140. Date accessed: 16-11-2019
8. American College of Obstetricians and Gynecologists. Practice Bulletin No. 143: Medical Management of First-Trimester Abortion. *Obstetrics & Gynecology* 2014;123.https://journals.lww.com/greenjournal/Fulltext/2014/03000/Practice_Bulletin_No__143___Medical_Management_of.40.aspx
9. Royal College of Obstetricians and Gynaecologists. The Care of Women Requesting Induced Abortion. 7. 2011. London, Royal College of Obstetricians and Gynaecologists. Evidence-based Clinical Guideline. www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf
10. World Health Organisation. Medical management of abortion. 2018. Geneva, WHO. www.who.int/reproductive-health/publications/medical-management-abortion/en/. Date accessed: 17-3-2020
11. Bracken, H., Clark, W., Lichtenberg, E. S., Schweikert, S. M., Tanenhaus, J., Barajas, A., Alpert, L., and Winikoff, B. Alternatives to routine ultrasound for eligibility assessment prior to early termination of pregnancy with mifepristone-misoprostol. *BJOG.* 2011;118:17-23.PM:21091926
12. Edwards, J. and Carson, S. A. New technologies permit safe abortion at less than six weeks' gestation and provide timely detection of ectopic gestation. *Am.J.Obstet.Gynecol.* 1997;176:1101-6.PM:9166176
13. Mol, B. W., van, der, V., and Bossuyt, P. M. Symptom-free women at increased risk of ectopic pregnancy: should we screen? *Acta Obstet.Gynecol.Scand.* 2002;81:661-72.PM:12190842
14. Ulmann, A., Silvestre, L., Chemama, L., Rezvani, Y., Renault, M., Aguilhaume, C. J., and Baulieu, E. E. Medical termination of early pregnancy with mifepristone (RU 486) followed by a prostaglandin analogue. Study in 16,369 women. *Acta Obstet.Gynecol.Scand.* 1992;71:278-83.PM:1322621

References

15. NICE. Ectopic pregnancy and miscarriage: diagnosis and initial management. NG126. 17-4-2019. London, NICE. NICE guideline. www.nice.org.uk/guidance/ng126
16. Raymond, E. G., Tan, Y. L., Comendant, R., Sagaidac, I., Hodorozea, S., Grant, M., Sanhueza, P., Van, Pratt E., Gillespie, G., Boraas, C., Weaver, M. A., Platais, I., Bousiequez, M., and Winikoff, B. Simplified medical abortion screening: a demonstration project. *Contraception* 2018;97:292-6.PM:29170088
17. Endler, M., Beets, L., Gemzell, Danielsson K., and Gomperts, R. Safety and acceptability of medical abortion through telemedicine after 9 weeks of gestation: a population-based cohort study. *BJOG*. 2019;126:609-18.PM:30456778
18. Endler, M., Lavelanet, A., Cleeve, A., Ganatra, B., Gomperts, R., and Gemzell-Danielsson, K. Telemedicine for medical abortion: a systematic review. *BJOG*. 2019;126:1094-102.PM:30869829
19. Kaneshiro, B., Edelman, A., Sneeringer, R. K., and Ponce de Leon, R. G. Expanding medical abortion: can medical abortion be effectively provided without the routine use of ultrasound? *Contraception* 2011;83:194-201. PM:21310279
20. Heller, R. and Cameron, S. Termination of pregnancy at very early gestation without visible yolk sac on ultrasound. *J.Fam.Plann.Reprod Health Care* 2015;41:90-5.PM:25201906
21. Society and College of Radiographers and British Medical Ultrasound Society. Guidelines for Professional Ultrasound Practice. Revision 4. 2019. London, SCoR & BMUS. Guidelines for Professional Ultrasound Practice. https://www.bmus.org/static/uploads/resources/Guidelines_for_Professional_Ultrasound_Practice_v3_OHoz76r.pdf
22. NICE. Routine preoperative tests for elective surgery. NG45. 5-4-2016. London, NICE. NICE guideline. www.nice.org.uk/guidance/ng45/resources/routine-preoperative-tests-for-elective-surgery-pdf-1837454508997
23. Horvath, S., Tsao, P., Huang, Z. Y., Zhao, L., Du, Y., Sammel, M. D., Luning Prak, E. T., and Schreiber, C. A. The concentration of fetal red blood cells in first-trimester pregnant women undergoing uterine aspiration is below the calculated threshold for Rh sensitization. *Contraception* 2020.PM:32135125
24. NICE. Sexually transmitted infections and under-18 conceptions: prevention. PH3. 28-2-2007. London, NICE. Public health guideline. www.nice.org.uk/guidance/ph3/resources/sexually-transmitted-infections-and-under18-conceptions-prevention-pdf-55452476869
25. Public Health England. National Chlamydia Screening Programme (NCSP). 29-4-2019. London, PHE. www.gov.uk/government/collections/national-chlamydia-screening-programme-ncsp. Date accessed: 17-3-2020
26. Royal College of Obstetricians and Gynaecologists, Faculty of Sexual & Reproductive Healthcare, and British Society of Abortion Care Providers. Clinical Guidelines for Early Medical Abortion at Home - England. 3-1-2019. London, RCOG/FSRH/BSACP. www.rcog.org.uk/en/guidelines-research-services/guidelines/early-medical-abortion-home-england/
27. Ashok, P.W., Templeton, A., Wagaarachchi, P.T., and Flett, G. M. Factors affecting the outcome of early medical abortion: a review of 4132 consecutive cases. *BJOG*. 2002;109:1281-9.PM:12452467
28. Bracken, H., Lohr, P.A., Taylor, J., Morroni, C., and Winikoff, B. RU OK? The acceptability and feasibility of remote technologies for follow-up after early medical abortion. *Contraception* 2014;90:29-35.PM:24815098
29. Perriera, L. K., Reeves, M. F., Chen, B. A., Hohmann, H. L., Hayes, J., and Creinin, M. D. Feasibility of telephone follow-up after medical abortion. *Contraception* 2010;81:143-9.PM:20103453

References

30. Public Health England. COVID-19: infection prevention and control. 2020. London, PHE. www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control
31. British Society for Gynaecological Endoscopy. BSGE Statement on Hysteroscopic Procedures and COVID-19. 2020. London, BSGE. www.bsge.org.uk
32. Dong, L., Tian, J., He, S., Zhu, C., Wang, J., Liu, C., and Yang, J. Possible Vertical Transmission of SARS-CoV-2 From an Infected Mother to Her Newborn. *JAMA* 2020.PM:32215581
33. Fan, C., Lei, D., Fang, C., Li, C., Wang, M., Liu, Y., Bao, Y., Sun, Y., Huang, J., Guo, Y., Yu, Y., and Wang, S. Perinatal Transmission of COVID-19 Associated SARS-CoV-2: Should We Worry? *Clin.Infect.Dis.* 2020.PM:32182347
34. Royal College of Obstetricians and Gynaecologists. Coronavirus (COVID-19) Infection in Pregnancy. (Version 5). 28-3-2020. London, RCOG. Information for healthcare professionals. www.rcog.org.uk/globalassets/documents/guidelines/2020-03-28-covid19-pregnancy-guidance.pdf
35. GMC. Consent: patients and doctors making decisions together. 2-6-2008. London, General Medical Council. www.gmc-uk.org/guidance. Date accessed: 16-3-2020
36. Faculty of Sexual & Reproductive Healthcare and British Association for Sexual Health and HIV. Standards for Online and Remote Providers of Sexual and Reproductive Health Services. 2020. London, FSRH & BASHH. Joint BASHH/FSRH Standard. www.fsrh.org/standards-and-guidance/documents/fsrhbashh-standards-for-online-and-remote-providers-of-sexual/
37. Royal College of Obstetricians and Gynaecologists. Obtaining Valid Consent. 2015. London, RCOG. Clinical Governance Advice No. 6. <https://www.rcog.org.uk/globalassets/documents/guidelines/clinical-governance-advice/cga6.pdf>. Date accessed: 16-3-2020
38. Allen, R. H. and Goldberg, A. B. Cervical dilation before first-trimester surgical abortion (<14 weeks' gestation). *SFP Guideline 2007*1. *Contraception* 2007;76:139-56.PM:17656184
39. IPAS. Paracervical Block Technique. 2019. www.ipas.org/resources/paracervical-block-technique. Date accessed: 14-3-2020
40. AoMRC. Safe Sedation Practice for Healthcare Procedures. 2013. London, Academy of Medical Royal Colleges. Standards and Guidance. www.aomrc.org.uk/wp-content/uploads/2016/05/Safe_Sedation_Practice_1213.pdf. Date accessed: 14-3-2020
41. World Health Organisation. Health worker roles in providing safe abortion care and post-abortion contraception. 2015. Geneva, WHO. www.who.int/reproductivehealth/publications/unsafe_abortion/abortion-task-shifting/en/
42. Borgatta, L. and Kapp, N. Clinical guidelines. Labor induction abortion in the second trimester. *Contraception* 2011;84:4-18.PM:21664506

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