



Category – Women's Health and Policies

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Infertility in West Africa: a systematic review of qualitative studies

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Objective This systematic review aims to provide a comprehensive overview of the experiences of those suffering infertility and subfertility in West Africa. The qualitative studies were analysed from a 10-year period. Emerging themes surrounding infertility and subfertility in this cultural setting were identified. This review highlights the need for the implementation of global public health interventions.

Design Systematic review of qualitative studies using a meta-ethnographic approach. Meta-ethnography has been used to synthesise the qualitative findings. It identifies the personal experiences of the study subjects and allows for appropriate thematic extrapolation.

Method Six databases were searched for primary qualitative studies, written in English between 2007 and 2017. Data from 17 eligible studies were extracted and the findings were analysed and synthesized with NVivo 11 software. Each of the 17 studies was subject to a Critical Appraisal Skills Programme (CASP) analysis for qualitative data.

Results The major themes emerging from the literature were the consequences of infertility ranging from psychological distress, union dissolutions, extramarital affairs, divorce, social ostracism, physical and sexual violence and questions surrounding gender identity. The emerging themes were heavily dependent on the perception surrounding the meaning of infertility. The interpretation of childlessness poses barriers to the development and implementation of appropriate interventions, as health engagement is variable across subcultures and dictated by local understanding and definitions of infertility.

Conclusion There are areas of opportunity for interventions and public health engagement that through education and sensitive delivery of reproductive care could result in positive changes for those dealing with the consequences of infertility in West Africa. Further research is required for culturally acceptable assisted reproduction technologies, male infertility impacts and exploration of psychological and social support for those suffering the effects of infertility and subfertility. It is essential to improve the lives of those living with infertility in this cultural setting.

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The impact of past maternal trauma on mother-infant interaction

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Objective To determine how maternal history of childhood abuse affects mother-infant interaction at 12 months.

Design Previous studies have demonstrated conflicting results on the influence of maternal childhood trauma on mother-infant interaction, with no consensus as to whether it induces maternal unresponsive or maternal controlling behaviours. A failure of most of these studies is they only evaluate one end of the maternal insensitivity spectrum. In addition, the infants contribution to mother-infant interaction is often overlooked, despite evidence that infant cooperation may affect maternal sensitivity. For this reason, in this study the CARE-Index video coding method is utilized, which assesses both mother and infant contribution to interaction, as well as both ends of the maternal insensitivity spectrum. Furthermore, this study also uses the Childhood Experiences of Care and Abuse Questionnaire (CECA-Q), which is a validated questionnaire used to determine if an individual has experienced neglect, physical, sexual or emotional abuse before the age of 18. Compared to other measures, the CECA-Q's primary strengths include the fact it accounts for multiple types of child abuse, that it explores abuse occurring inside and outside of the nuclear family and that the severity of abuse is accounted for.

Method 50 dyads who had completed CECA-Q and a CARE-Index video at 12 months old, from the Psychiatry Research and Motherhood Depression (PRAM-D) study, were selected for analysis. The dyads were selected by a researcher who was not part of this project, to ensure coders were blind to the trauma status of each dyad. 27 of these dyads formed the trauma group and the remaining 23 dyads formed the non-trauma group, based on CECA-Q scores. Dyadic synchrony, maternal sensitivity, maternal unresponsiveness, maternal control and infant cooperativeness were evaluated using the CARE-Index method, and group scores were compared using independent samples T-tests.

Result: Maternal childhood trauma did not significantly affect dyadic synchrony ($P = 0.31$), maternal sensitivity ($P = 0.20$), maternal unresponsiveness ($P = 0.73$), maternal control ($P = 0.10$) or infant cooperativeness ($P = 0.43$).

Conclusions Consistent with other studies, dyadic synchrony and maternal sensitivity scores were not associated with maternal childhood experiences of abuse at 12 months. However, maternal control, maternal unresponsiveness and infant cooperativeness scores were not found

to be affected by trauma, in contrast to prior studies. This is thought to be due to the relatively small sample size and not accounting for the effect of trauma type.

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Fertility preservation for medical reasons – the gap between guidance and access

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Objective To evaluate fertility preservation provision in the UK. Variation in IVF provision across clinical commissioning groups (CCGs) in England is known. We investigated whether variation in fertility preservation provision also exists between CCGs and Health Boards in England, Scotland, Wales and Northern Ireland with a view to identifying fair models of provision.

Design This was an assessment of current fertility preservation policies in the UK. Separate fertility preservation funding policies apply to each of the 135 CCGs in England, 14 Health Boards in Scotland, 7 Health Boards in Wales and 5 Trusts in Northern Ireland. Fertility preservation provision within each region was compared to NICE guidelines.

Methods We reviewed a total of 161 fertility preservation policies for England, Scotland, Wales and Northern Ireland. Where these were unavailable online, CCGs and Health Boards were contacted to provide information under the Freedom of Information Act 2000. Funded procedures, conditions and duration of storage were noted. Each policy was reviewed by two independent assessors.

Results In England, 127/128 (99%) CCGs provided funding for cryopreservation of oocytes, sperm and embryos, whilst 1 CCG required an individual funding request. Cancer was the exclusive indication in 11%. Fertility preservation provision for individuals with gender identity dysphoria is specified in 28%, ovarian tissue cryopreservation is funded in 8% and storage funding varies from five to ten years between CCGs in England. In Scotland, a national policy is applied. All 14 health boards equitably fund cryopreservation of oocytes, sperm, embryos and ovarian and testicular tissue. Funding is provided for cancer, medical conditions which may impair fertility and for individuals with gender identity dysphoria. Storage funding is based on a five-yearly review to assess ongoing need for storage until age 43 in women and 60 in men.

In Wales and Northern Ireland, cryopreservation of oocytes, sperm and embryos is funded for people undergoing medical or surgical treatment likely to make them infertile, provision for individuals with gender identity

dysphoria is not specified and ovarian tissue cryopreservation is not funded.

Conclusions Although fertility preservation is funded in all UK nations, our study identified considerable variation in criteria and duration of funding. Notably, funding for gender identity dysphoria and ovarian tissue cryopreservation was inconsistent in England, Wales and Northern Ireland and should be challenged. The national policy in Scotland was found to be most inclusive. International review of fertility preservation policies is recommended to assess and address inequalities in fertility preservation provision across the globe.

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Addressing inequality at birth using caseload midwifery in a deprived inner-city population **Hadebe, R¹; Seed, P²; Essien, D¹; Headen, K¹; Mahmud, S²; Owasil, S³; Fernandez Turienzo, C²; Stanke, C⁴; Sandall, J²; Oteng-Ntim, E^{1,2}**

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Objectives (1) To report maternal and newborn outcomes of pregnant women in areas of social deprivation in inner-city London. (2) To compare the effect of caseload midwifery with standard care on maternal and newborn outcomes in this cohort of women.

Design Retrospective observational cohort study.

Setting Four council wards in inner-city London, where over 90% of residents are in the two most deprived quintiles of the English Index of Multiple Deprivation (IMD 2015) and the population is ethnically diverse.

Participants All women booked for antenatal care under Guys and St Thomas' NHS Foundation Trust after 11/7/2018 (when the Lambeth Early Action Partnership (LEAP) caseload midwifery team^a was implemented) until data collection 18/6/2020. This included 523 pregnancies in the LEAP area, of which 293 were allocated to caseload midwifery, and 8430 pregnancies from other areas. Main outcome measures: To explore if targeted caseload midwifery (known to reduce preterm birth) will improve important measurable outcomes (preterm birth, mode of delivery, and newborn outcomes).

Results There was a significant reduction in preterm birth rate in women allocated to caseload midwifery, when compared to those who received traditional midwifery care (5.1% CL versus 11.2%; risk ratio: 0.45; $P = 0.04$; confidence interval 0.21 to 0.96; number needed to treat: 14.9). Caesarean section births were significantly reduced in women allocated to caseload midwifery care, when compared to traditional midwifery care (24.3% versus 38.0%;

risk ratio: 0.64; $P = 0.01$; confidence interval: 0.46 to 0.89; number needed to treat: 7) including emergency caesarean deliveries (15.2% versus 22.5%; risk Ratio: 0.58; $P = 0.02$; confidence interval: 0.36 to 0.92; number needed to treat: 9.5) without increase in neonatal unit admission or still-birth.

Conclusion This study shows that a model of caseload midwifery care implemented in an inner-city deprived community improves outcome by significantly reducing preterm birth and delivery by caesarean section when compared to traditional care. These data trend suggests that when applied to targeted groups (women in higher IMD quintile and women of diverse ethnicity) that the impact of intervention is greater.

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HPV vaccination in LMICs: a thematic analysis of attitudes and implementation strategies

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Objective To identify the attitudes towards the Human papillomavirus (HPV) vaccine amongst parents/guardians, the target population, healthcare providers and school staff in low- and middle-income countries (LMICs), and identify effective strategies to implement a HPV vaccination programme.

Design This paper demonstrated a systematic approach to a literature review. Literature highlights a quantitative understanding of the low uptake of the HPV vaccine within LMICs. As such, this has provided a lacuna for a qualitative assessment of the attitudes towards the HPV vaccine, and consideration of effective methods to combat barriers within HPV vaccination programmes.

Method Inclusion criteria consisted of studies conducted in LMICs from 2006 onwards, with a focus on attitudes amongst the stakeholders. Six databases and sources of grey literature were systematically searched. Leading critical appraisal tools were used to screen the literature for high-quality evidence. Attitudes of acceptance and hesitancy were thematically analysed using a thematic framework. The final framework consisted of three domains of attitude of hesitancy and support; (1) Contextual factors, (2) Individual group influences and (3) Vaccine/Vaccination specific factors. Citation frequencies within each domain were visually presented. Effective implementation strategies were highlighted following a systematic literature review.

Results Sixty-three papers from sixteen LMICs were included in the final review. Beliefs and attitudes about health prevention, religion/cultural factors, and perceived risks/benefits were common themes across attitudes of support and hesitancy throughout the four stakeholder groups.

The trust of a healthcare professional was commonly reported amongst parents/guardians and the target population. Overall, hesitant attitudes received more citations than acceptance. This finding indicates the possibility of reporting bias, as hesitant attitudes were described with more detailed. Important vaccine delivery strategies include: a school-based delivery approach, an educational focus within outreach activities, and the collaboration of officials and community leaders.

Conclusions The HPV vaccine receives mixed reviews across LMICs. Themes across the stakeholders centred around knowledge, sociocultural influence and exposure. Vaccine co-ordinators in LMICs should conduct a representative assessment of stakeholder attitudes prior to vaccine rollout. Outreach and sensitisation efforts should be prioritised with a focus on increasing knowledge about the vaccine, and vaccine activities should account for contextual needs by collaborating with respected influential individuals. This review was completed in 2018, however, important parallels can be drawn with the current climate in 2021 posed by the introduction of the COVID-19 vaccine.

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Is the process of retraction of fabricated RCTs in obstetrics/gynaecology working?

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Objective Randomized controlled trials (RCTs) are recognized as scientific investigations that have the least potential for bias and are therefore widely used to direct clinical practice. Detection of integrity problems and subsequent action is therefore of imminent importance. We studied how journal editors and publishers respond to randomised clinical trials in reproductive medicine that are identified as fabricated?

Design Observational study.

Methods We studied 52 articles of four authors who have fabricated studies in obstetrics/gynaecology. Data fabrication was clear from duplicate baseline and outcome tables in studies on different interventions done in different patients in different periods. Our findings are in the public domain for three of the four authors, with another article in submission.

We first approached the authors and their institutes for an explanation. We then notified the editors of the involved 14 journals in February 2020, as well as the universities where two of the authors had been awarded a PhD.

Results Two articles had already been retracted prior to our notification. Twelve months after we notified the editors, 4/50 (8%) (1 journal) of the articles had been retracted, 3 (6%; 2 journals) were formally investigating with notification on their website, 6/50 (8%; 3 journals) were informally investigating (without visible notification), 3/50 (6%; 1 journal) had made an expression concern and stated 'caution that clinical practice or guidelines should not be based on this report' without formal retraction, and one (2%) had investigated original data and cleared it (although numerous data were identical to a study published 10 years earlier). For the other 33 articles (66%; 11 journals) no visible action had been taken. The University of Utrecht and the Vrije Universiteit Brussels had not taken any action against the awarded fraudulent PhDs.

Among the reactions of editors were the statements 'I have been in the business long enough; It exists in all specialties and in every country', 'we receive 80 submissions a week, I am too busy to respond on this' and 'we did still not get an answer about the result of the investigation by the local court'.

Conclusions Retraction of fabricated studies is seldom happening, and a majority of journals are not following COPE. This not only puts patients at risk, but let's whistle-blowers down and jeopardizes the trustworthiness of research. COPE-regulations consider the interests of authors and publishers, but not the interest of patients.

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The significance of benign gynaecological conditions upon levels of morbidity in LMIC
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Objective To estimate the burden of morbidity due to benign gynaecological conditions (BGC) suffered by women and girls in low- and middle-income countries (LMIC) compared to the morbidity caused by HIV/AIDS, TB & Malaria.

Design The Global Burden of Disease database (GBD) represents the most systematic attempt to gather information regarding global patterns of BGC. We analysed morbidity data for all BGC included in the GBD, as measured through 'years lost to disability' (YLD). YLD represents the

number of years with a lower quality of life due to a disease and is an effective measure of morbidity.

Methods Data were extracted using the GBD results tool for: uterine fibroids, polycystic ovary syndrome, female infertility, genital prolapse, endometriosis, miscarriage and abortion, ectopic pregnancy and pelvic inflammatory disease. The burden of disease for individual conditions and BGC overall was calculated as a proportion of overall disease burden from all conditions. The data was sub-categorised by age, world bank income level and selected region and country. For comparison, the same analysis was undertaken for HIV/AIDS TB & Malaria.

Results Data from this analysis shows that in LMIC overall, morbidity due to BGC outweighs the combined morbidity from HIV/AIDS, TB & Malaria. This general finding applies across all income levels except low-income countries (most notably sub-Saharan Africa) where BGC related morbidity is second to morbidity from HIV/AIDS. In LMIC overall, the proportion of YLD from all BGC is 1.62%; the combined proportion from HIV/AIDS, TB & Malaria is 1.05%. In LMIC outside sub-Saharan Africa (South Asia, East and North Africa, Latin America and Caribbean, Europe & Central Asia, East Asia & Pacific), YLD from BGC far outweighs that from HIV/AIDS, TB & Malaria; 1.73% compared to 0.35%. Even in Upper middle-income countries, the disparity is pronounced at 2.04% for BGC versus 0.62% for HIV/AIDS, TB & Malaria. Amongst women of reproductive age in LMIC, the leading causes of morbidity are 'endometriosis' and 'fibroids'. Importantly, the nature of studies contained in the GBD database mean these classifications of 'fibroids' and 'endometriosis' actually encompass a broad range of menstrual problems.

Conclusion This data demonstrates an urgent need for governments and international organisations working in LMICs to prioritise the treatment and prevention of gynaecological conditions. Programmes such as the RCOG 'Essential Gynaecological Skills' course may help achieve this through training, task-shifting and better utilisation of pre-existing resources.

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Clinician-led transformation of sexual and reproductive healthcare in NI post-decriminalisation of abortion

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Objective This paper outlines how, in the absence of commissioning or support from the NI Department of Health (DoH), NHS early medical abortion (EMA) services

were rapidly implemented in response to COVID-19 travel restrictions. It demonstrates how clinician-led collaborative working can transform sexual and reproductive healthcare (SRH) despite considerable political resistance.

Design Post-decriminalisation in October 2019, clinicians seeking to influence policy established the NI Abortion and Contraception Task group (NIACT), a multidisciplinary, multisector group with representation from clinicians, academics, service users and the charity sector.

COVID-19 travel restrictions meant that women were unable to access treatment in England and local services were urgently required. NIACT established a regional central access point through Informing Choices NI (ICNI), facilitating self-referral and counselling. Non-funded EMA services were simultaneously implemented within existing Sexual and Reproductive Health services across all five Trusts.

NIACT subsequently developed a strategy report, making evidence-based recommendations on better sex education, accessible contraception and the delivery of safe compassionate abortion care within high-quality SRH services.

Method Since April 2020, data has been collected concurrently on the number of women self-referring to ICNI, accessibility to Trust services, waiting times, patient outcomes, contraceptive uptake and service user feedback. This data was used to provide an evidence-base for the NIACT strategy to inform the development of high-quality SRH in NI post-decriminalisation.

Results EMA is currently available in all five Trusts but is not yet commissioned and relies heavily on the good will of dedicated clinicians. Demand remains high with over 40 women per week self-referring to ICNI. Waiting times are short, uptake of long-acting reversible contraception is high and service user feedback is excellent.

Mifepristone is not permitted for home use in NI, which necessitates a clinic visit. Due to the temporary cessation of two Trust services, the absence of surgical services or treatment beyond 10 weeks gestation, many women still needed to travel to England during the pandemic.

Conclusions NIACT have demonstrated how an integrated model of sexual and reproductive healthcare can work well within the NHS in NI. However, to ensure the sustainability of new services and develop a comprehensive abortion service, DoH commitment and commissioning are required. The NI Human Rights Commission have commenced a judicial review; it is anticipated that this will be successful in initiating the commissioning process. It is envisioned that NIACT's strategy will be utilised to inform the development of world-class sexual and reproductive healthcare in NI.

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Perceptions of abortion care teaching: preparing medical students for practice

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Objective To explore medical students' perceptions regarding the current provision of abortion care teaching, and to evaluate the extent to which this teaching may prepare students for their subsequent clinical practice as doctors.

Design Semi-structured interviews were conducted using an interview topic guide formulated by reference to relevant research literature. Transcribed interviews were then coded to allow for a systematic thematic analysis. This represents a needs-focussed approach, in order to allow students to participate as stakeholders to inform curriculum design and development.

Method We interviewed 8 students who had completed their obstetrics and gynaecology placement within the last year at a number of different teaching hospitals affiliated with Imperial College School of Medicine. Interviews were conducted remotely between August and October 2020, then transcribed and reviewed by the research team. Interview data was coded into the qualitative data management tool NVIVO and thematic analysis was undertaken using the technique described by Braun and Clarke (2006). All researchers analysed the transcripts and identified common themes through an iterative process.

Results Analysis of the interview transcripts revealed that 5 core themes encompassed student perceptions of abortion care teaching. These were: perspectives on educational experiences of abortion care, understanding of legal frameworks and responsibilities, identifying and addressing learning needs, preparedness for clinical practice and suggestions for future training and curriculum development.

Conclusions Whilst this exploratory study only involved 8 interviews across 3 teaching hospitals, the data was sufficiently rich to provide key insights into how students perceived preparedness for practice in abortion care and how the pandemic has impacted upon clinical learning opportunities. Students reported a range of different educational experiences of abortion care, with varying exposure suggesting non-standardised teaching across different sites. The coronavirus pandemic was also cited as a factor exacerbating these discrepancies in exposure to abortion care teaching. Irrespective of individual clinical exposure and

experience, students reported feeling underprepared for clinical practice, suggesting abortion care teaching could be improved at the undergraduate level and warrants further study.

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Increasing skilled birth attendance: establishing a midwifery-led clinic in rural Uganda

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Objective The World Health Organization concludes that skilled attendance during childbirth is 'the single most important factor in preventing maternal deaths'. Maternal health in Uganda lags behind both national and international targets, and is negatively impacted by marked poverty levels; geographical inaccessibility; lack of transport; and gender inequality. Despite 50% improvement since 1990, Uganda's maternal mortality ratio (deaths per 100 000 live births) is estimated at 375; approximately 50 times higher than the UK's (World Bank, 2017). Multiple contributory factors exist, grouped into a model of three overarching delays: health-seeking behaviours; care accessibility; care quality. Our charity established a midwifery-led clinic in rural Western Uganda, which targets all three delays: we report on the first year of operation.

Case report After three years running six-weekly outreach antenatal clinics in Kyarushesha village, we opened a permanent clinic in March 2020, funded by UKAid Direct, providing round-the-clock care for childbirth and obstetric emergencies, alongside daily antenatal clinics, and regular family planning clinics and childhood immunisations. It reduces the number of families living more than 5 km from a health facility, enhancing access to skilled medical staff, medical resources and comprehensive referral services, thereby increasing skilled birth attendance and health facility delivery and decreasing serious pregnancy complications.

In the first eleven months, we have seen 3448 patients for antenatal appointments (monthly mean 313, standard deviation (SD) 43), delivered 319 babies (monthly mean 29, SD 9) and provided family planning to 646 people (monthly mean 59, SD 15). There have been no maternal deaths, and four stillbirths (rate 1.3%, compared to 3.7% reported by the local regional referral hospital).

The clinic currently occupies leased premises, but we are constructing our own purpose-built facility to improve and

expand our services, and reduce the monthly running costs to secure the clinic's long-term sustainability.

Discussion This project directly targets Sustainable Development Goal 3 by increasing access to fundamental health services for communities unable to access other facilities. The local district development plan (2015–20) outlined opening a similar facility here, but this had not happened. Before this clinic, the nearest health facility providing skilled birth attendance was 25 km away, and therefore physically and financially inaccessible to many.

Conclusion Establishing a midwifery-led clinic serving 11 deprived villages in rural Uganda (estimated population 50 000) has increased access to skilled birth attendance, health education and antenatal care, plus family planning and childhood immunisations, for some of the world's poorest families.

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Outcomes of unbooked pregnancies in a Singapore tertiary centre

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Objective Antenatal care (ANC) has been observed to improve maternal and perinatal outcomes, which is thought to be through detection and treatment of pregnancy-related complications and identification of women at risk of developing complications allowing institution of preventative measures. However, majority of studies are focused on lower and middle-income countries, with no local data published to date. Through this study, we aim to evaluate the impact on maternal and perinatal outcomes in unbooked pregnancies in a higher-income country like Singapore.

Design A retrospective single-centre cohort study of KK Women's and Children's Hospital (KKWCH), the largest maternity facility in Singapore, from January 2015 to December 2019.

Method The database was reviewed, selecting for indicators of maternal and perinatal outcomes and comparing it between the unbooked group and the rest of the population.

Results A total of 58 107 women delivered in KKWCH between January 2015 and December 2019, of which 2.7% ($n = 1525$) were unbooked. Women in the unbooked group were more likely to be unmarried (19.5% versus 9.5%) but the average age was similar (30.0 versus 30.5). Majority of the women delivered via normal vaginal delivery (68.7% in unbooked group versus 60.9% in general population). 3.1% ($n = 47$) of the women in the unbooked group had an instrumental delivery compared to 6.2% ($n = 3494$) in the general population. Rates of caesarean

sections appeared to be lower in the unbooked population (27.5% versus 32.7%) however there was a much higher proportion of emergency caesareans (88.6% versus 60%). There was also an increased rate of vaginal breech deliveries in the unbooked population (0.7% versus 0.2%). There were a total of 4 maternal deaths, 1 of whom was unbooked (25%). There was an almost three-fold increase in the requirement for blood product transfusions (8.5% versus 3.3%) as well as maternal ICU admissions (1.9% versus 0.6%) in the unbooked group. Neonatal ICU stay was similar in both groups (2.3% versus 2.1%). There were 10 intra-uterine deaths (0.7%) in the unbooked group. Within the unbooked group, 34.7% ($n = 529$) of babies had low birth weights < 2500 g and 8.3% ($n = 127$) were macrosomic.

Conclusion Although the proportion of unbooked pregnancies are low, these women are more likely to have an emergency caesarean section or vaginal breech delivery, require blood product transfusions and ICU stays as compared to the general population. More work is required to explore reasons for non-engagement to encourage uptake of ANC in this population.

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Obstetrics & Gynaecology in International Clinical Practice Guidelines for gender minority/trans people

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Objective To identify and critically assess published international clinical practice guidelines (CPGs) concerning the care of gender minority/trans people, and comment on relevance to Obstetrics and Gynaecology.

Design Systematic review and quality assessment using Appraisal of Guidelines for Research and Evaluation tool (AGREE II)[1].

Method Prospectively registered protocol, searches of 6 databases and 6 CPG websites, and international key opinion leaders approached. CPGs with any health-related intervention connected to the care of to gender minority/trans adults and/or children were included, with no exclusions due to comorbidities except differences in sex development. Outcomes included: number and quality of international CPGs, information on mortality or quality of life (QoL), consistency of recommendations, and appraisal of key messages for patients. Relevance of extracted data (including key recommendations) to obstetrics and gynaecology was noted.

Results 12 international CPGs addressed gender minority/trans people's healthcare. Quality scores were wide-ranging, whichever AGREE II domain was prioritised, although a general pattern emerged: 5 higher-quality CPGs focused on HIV and other blood-borne infections (overall assessment scores 69–94%), whereas 6 lower-quality CPGs focused on transition-specific interventions (overall assessment scores 11–56%). No CPG primarily focused on obstetrics and gynaecology specific to gender minority/trans people. Limited information on mortality and QoL did not include any maternal or fetal outcomes. Of extracted key recommendations, pregnant women were identified as a target population in 2 of the HIV-related CPGs. No CPG included gender minority/trans specific key recommendations on contraception or abortion, the management of pregnancy, childbirth, or gynaecological diseases. An absence of detailed guidance on obstetric or gynaecological best practice following transition-related interventions was noted (e.g. management of testosterone-induced vaginal atrophy, or monitoring post gender-affirming hysterectomy/salpingo-oophorectomy). No CPGs provided key messages for patients.

Conclusions International CPGs for gender minority/trans people lack coverage of gynaecological and obstetric concerns. This may be associated with a paucity of primary data and lack of systematic reviews in this area, which ought to be addressed by recruitment to research. Extant CPGs are largely limited to the HIV epidemic and transition, and assessment of their quality revealed areas for improvement. International Obstetric and Gynaecology organisations may wish to develop high quality recommendations for gender minority/trans people. Future CPGs should aim for high standards according to the AGREE II framework, and include stakeholder involvement, unbiased processes and external review.

1. AGREE Next Steps Consortium (2017) The AGREE II Instrument [Electronic version]. <http://www.agreetrust.org>.

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Exploring the experience of providing abortion care: a mixed methods scoping review

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Objective Abortion care can be described as 'dirty work' and providers have noted negative impacts regarding their involvement in the services. Over the last decade, there has been a steady increase in research exploring the experiences of providers, yet no one has sought to systematically review this literature base to date. The aim of this review was to

synthesise published data that has explored the experiences of abortion care providers.

Design A scoping review.

Method A systematic search was conducted in six databases (CINAHL, Cochrane, EMBASE, PsycInfo, PubMed, Web of Science). Articles were included if they explored experiences that were directly related to providing abortion care. The search was restricted to English language studies only. Qualitative and quantitative evidence were synthesized using Arksey and O'Malley's framework¹ and a quality appraisal was conducted on all articles using the Mixed-Methods Appraisal tool².

Results The search identified 6627 titles. Seventy-five of these studies were included in the review: 57 qualitative, 12 quantitative, and six mixed methods. These report on a sample of 3008 abortion care providers from 25 countries and six continents: Europe (28), North America (21), Africa (16), Asia (seven), South America (four), and Oceania (two). The oldest article was published in 1993 and 60 have been published since 2010, highlighting the rising interest in this area. The most common issues discussed were personal challenges, most notably moral or ethical challenges posed by abortion care. The providers also noted challenges related to the society (e.g. restrictive legislation and societal disapproval of abortion) and communities (e.g. stigma) in which they lived, as well as the institutions where they worked (e.g. unsupportive management, interactions with colleagues and patients). Finally, the providers noted positive aspects of providing care such as pride taken in abortion work and the strength of like-minded collegial networks.

Conclusions This review offers a comprehensive overview of abortion care providers' experiences. Similar experiences, both positive and negative, were highlighted by many of the providers regardless of their location around the world. Future research in this area can build on these findings, potentially running or creating new interventions that may reduce the negative impacts experienced by the providers.

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Methods and indications for late pregnancy termination and feticide in European countries Pitkēviča, I¹; Pumpure, E²; Rezeberga, D²

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Objective Where the fetal abnormality is not lethal and termination of pregnancy is attempted after 22 weeks of gestation, absence of feticide could result in a live birth, an outcome that contradicts the intention of the abortion. The study aims to understand action for late termination of pregnancy and methods and indications for feticide among European countries.

Design A cross-sectional survey with multiple-choice questions and open answers was made in the English language.

Method An online questionnaire was sent to randomly selected gynaecologists in Europe. The study was conducted from January 2020 until January 2021. Data were collected and analyzed using Microsoft Excel.

Results Answers were received from 18 countries: Austria, Croatia, the Czech Republic, Denmark, Estonia, France, Greece, Latvia, Lithuania, Malta, the Netherlands, Norway, Poland, Portugal, Slovenia, Switzerland, Turkey and the United Kingdom. Pregnancy termination was defined by law in all countries, except Malta. First-trimester screening from 11 to 13 + 6 weeks of gestation was performed in 15 countries (not performed in Malta and Norway, recommended but not paid from health insurance in Slovenia). Second-trimester screening from 20 to 22 + 6 weeks of gestation was performed in 16 countries, from 18 weeks of gestation in Norway and Poland. Pregnancy termination for medical indications can be performed in 17 countries, in 6 countries without a definite period. In 8 countries abortion due to medical indications was not allowed if fetal weight ≥ 500 grams and/or ≥ 24 weeks of gestation. In 12 countries late pregnancy termination was performed using misoprostol or surgically. Feticide was performed in 13 countries (except Norway, Lithuania, Poland, Malta and Croatia) mainly by a gynaecologist. Indications for feticide: pregnancy termination after 21 + 6 weeks of gestation, psychosocial reasons, women's request. Reasons for feticide: to facilitate and induct termination, ethical, psychoemotional. Most used method for feticide was transabdominal intracardiac administration of potassium chloride. Reasons why feticide was not performed: legal, ethical, religious, non-acceptance by society. Consent 'not to resuscitate' can be signed in 5 countries: Austria, Estonia, France, the Netherlands and the United Kingdom.

Conclusions Late termination of pregnancy and feticide is associated with ethical, legal and psychoemotional barriers. It is essential to establish a direct methodology for

gynaecologists and ensure that every woman in Europe has equal rights and possibilities to receive generally accepted procedures and manipulations.

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Pregnancy outcomes, complications and experiences in obstetrics and gynaecology registrars

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Introduction Registrar training is a stressful time associated with long working hours and strenuous physical activity that may impact pregnancy outcomes. There are few international and no South African studies which investigate the impact of registrar training on an obstetrician's own pregnancy.

Objective This study aims to evaluate pregnancy outcomes and complications of women who fell pregnant during their obstetrics and gynaecology (OBGYN) registrar time in South Africa.

Study design A retrospective, nationwide case-control study was conducted.

Methods

OBGYN ($n = 34$) and psychiatry ($n = 26$) registrars, specializing within the past 11 years, and partners of male obstetrics and psychiatry registrars ($n = 19$) completed an anonymous, online questionnaire. Psychiatry registrars, and partners of male registrars formed two separate control groups. Questionnaire data included demographics, pregnancy-specific questions and working-condition related questions. The data was managed using REDcap and analyzed retrospectively.

Results A positive pregnancy outcome was recorded for 86.4% of obstetricians, 96.7% of psychiatrists and 77.8% of spouses. 48% of obstetricians and 50% of psychiatrists compared to 37% of spouses reported at least one pregnancy complication ($P = 0.436$). Working more than 17 h in theatre (RR 1.95 CI 1.04–3.84) or more than 81 h per week (RR 2.12 CI 1.20–3.84) was significantly associated with an increased relative risk of a complicated pregnancy in OBGYN registrars. OBGYN registrars had more night calls and hours of standing, less hours of sleep per call and greater exposure to hazardous substances compared to psychiatry registrars ($P < 0.01$). Preterm births were significantly more prevalent amongst psychiatrists compared to the other two groups ($P = 0.005$). All obstetric registrars (100%) identified long hours and night calls as the predominant causes of stress in pregnancy.

Conclusion These results suggest that registrars working in South African hospitals have a high proportion of pregnancy complications. Adverse working conditions

associated with OBGYN registrar training such as long hours, particularly in theatre, may be associated with pregnancy complications. Policies need to be put in place to address these working conditions for pregnant obstetricians during registrar training.

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Structural violence in experiences of adolescent pregnancy in Bogota

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Objective Colombia has been criticised for its high rates of adolescent pregnancy, with 20% of adolescents already child-bearing. The displaced population, who have been forced to migrate as a result of the ongoing violent conflict, face many social disadvantages including health inequalities. There are also higher rates of adolescent child bearing compared to the non-displaced population. Inequalities may represent structural violence, a term used to explain ways in which structures embedded within a society limit an individual's ability to reach their full potential. Despite a considerable number of people experiencing adolescent pregnancy and motherhood in the situation of displacement, there is a lack of qualitative information from the perspectives of the people whom it affects. The aim of this research is to explore how structural violence may feature in the lives of women who experience adolescent pregnancy in the situation of displacement in Colombia.

Design Qualitative methods were most appropriate to gather insight about the context and experiences of adolescent pregnancy and motherhood.

Methods Data was collected through semi-structured in-depth interviews, conducted in Ciudad Bolivar, in the south of Bogotá between June–August 2016. This included 11 interviews with women who had begun child bearing between the ages of 15 and 19 in the past 10 years and were living in the situation of displacement. Data was analysed and emergent themes were categorised using thematic analysis.

Results Participants had varying perceptions of whether adolescent motherhood was problematic, largely dependent on the forgone opportunities that pregnancy was associated with, importantly education. Participants had experiences of minimal support from family, partnerships nor the community, and felt let down by the state support system for displaced people. Structural violence was embedded in life stories, manifesting with experiences of poverty and difficulties accessing income, poor access to healthcare, and compromised access to education as a result of institutional

and interpersonal discrimination against adolescent mothers.

Conclusions Pregnancy during adolescence was a contradictory experience with benefits and disadvantages, largely a result of structural factors. The unequal opportunities brought about by mass institutional and interpersonal discrimination, as well as the culturally perpetuated prejudices towards young mothers, contributed to the difficulties of motherhood, causing avoidable suffering. The notion that age itself is a problem in adolescent pregnancy should be reconsidered, and instead more attention should be given to the systematic disadvantages and inequalities that have rendered adolescent pregnancy in the situation of displacement problematic.

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Acceptability of the first trimester anomaly scan amongst parents in the UK

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Objective Assessment for fetal anomalies is not currently offered as part of the UK screening programme at the 11–14 week scan. We explored parental views of a potential screening programme.

Design Multi-centre, prospective study including two cohorts.

Methods In cohort A, parents attending routine antenatal ultrasound at one of ten participating hospitals in England and Wales were eligible for recruitment. In cohort B, parents with a previous pregnancy or child with a congenital anomaly were invited to participate via two national charities. All participants received information explaining the potential benefits and disadvantages of 11–14 week anatomical assessment, and were asked to complete a validated, structured questionnaire on their views regarding such screening.

Results Overall, 1373 parents were recruited between November 2019 and January 2021, including 1199 in cohort A and 174 in cohort B. Most would opt for an 11–14 week anomaly scan in a future pregnancy (cohort A: 91%, cohort B: 95%). Reasons included early reassurance (A: 86%, B: 74%), desire for early information (A: 83%, B: 87%), time to prepare for the birth of an affected child (A:

68%, B: 46%), earlier access to genetic testing (A: 68%, B: 74%), additional time to consider pregnancy termination (TOP, A: 53%, B: 59%) and opportunity for earlier TOP (A: 48%, B: 65%). In parents declining the scan (A: $n = 35$ [3%], B: $n = 3$ [2%]), the main reason cited was increased anxiety due to inconclusive results. The majority of parents preferred having a diagnosis at 11–14 weeks for lethal anomalies (A: 89%, B: 95%) and severe anomalies (A: 87%, B: 95%). Most wanted minor conditions assessed as well (A: 77%, B: 79%); and to be informed of a suspected anomaly even if this could not be confirmed until a later gestation (A: 75%, B: 82%). Parents felt an earlier diagnosis might impact decisions regarding TOP (A: 58%, B: 37%). Of the 198 parents declining Combined Screening in this pregnancy, 71% would consent to an early anatomy assessment if offered in future. Parents considering TOP for severe/lethal anomalies were more likely to opt for early screening ($P < 0.001$) and to request information about minor anomalies ($P < 0.001$) and suspicious findings ($P < 0.001$).

Conclusions In this large, nationwide study, we have shown that most parents would consent to early anomaly screening at the 11–14 week scan, in addition to the 18–20 week anomaly scan currently offered by the National Health Service.

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Adapting RCOG clinical guidance to local settings **Sheppard, N¹; Mwanza, J²; Chipato, T³; Kavanagh, J¹; Parnham, E¹; Krediet, M¹**

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Objective The RCOG produces guidance to aid good clinical practice. Guidance documents present recognized methods and techniques for clinical practice, based on published evidence, for consideration by relevant healthcare professionals. Clinicians often wish to adapt existing guidance from authoritative sources, rather than developing their own de novo. The adaptation of existing guidance has advantages:

- It removes the need for the time-and skill-dependent steps of literature search and critical appraisal.
- Clinicians, policy makers and service users from the intended setting can bring their local perspectives to the recommendations, ensuring that these accord with local culture, available services and interventions.

Case report The RCOG's Centre for Women's Global Health worked remotely with Fellows and Members to adapt and endorse Best Practice Papers on Postpartum Family Planning and/or Comprehensive Abortion Care

and/or Post-Abortion Care to make them specific to local country contexts.

The papers set out the essential elements of high-quality services. The best practices described are drawn from current evidence-based guidance. The papers are designed to be readable and useful, and are therefore short and succinct. They are aimed at staff providing health care on a daily basis; trainees and medical students; advocates and policy-makers looking to move their services forward. Five RCOG Fellows and Members from Pakistan, Bangladesh, Kenya, Zambia and Zimbabwe were recruited as 'Champions' in a response to a call for applications. They demonstrated a need to update existing, or establish new, contraception and/or abortion guidelines within their contexts, as well as a readiness by key stakeholders to adopt and implement change.

Discussion Developing generic clinical Best Practice Papers and providing remote technical support to the adaptation

process, while working through carefully selected Champions to adapt the papers to local country contexts, has been shown to be an effective approach. The process worked well, and the papers were adapted and endorsed as national clinical guidance by the respective governments in all five countries.

Conclusion In some contexts, clinical guidance on specific areas doesn't exist or conversely, multiple guidelines exist and one document is desirable. Providing remote support to local Champions, who in turn work through official channels to advocate for local ownership of the process, has proved a successful approach. Adapting pre-existing guidance also expedited the process of guidance development. Through the Making Abortion Safe programme, the RCOG will continue to use this model to adapt Best Practice Papers in five further countries.