Medication Abortion Toolkit

Barriers to accessing abortion can be lowered by medication abortion. Medication abortion can simplify the process by taking abortion pills at home, meanwhile minimizing physical contact with health care providers.

According to the resolution on No and Low Touch Medication Abortions passed in 2021, and moved by Planned Parenthood and South Riverdale Community Health Centre, Alliance members had agreed to strive towards ensuring the availability of no and low-touch medication abortions as a part of comprehensive sexual health services.

In partnership with National Abortion Federation (NAF) Canada in February 2022, the Alliance offered an online training course for primary care providers. The topics of the training included medication abortion protocols, patient-centered counselling, and how to offer medication abortion in a primary care setting.

The Alliance is partnering with Planned Parenthood to continue to share resources to support the implementation of no and low-touch medication abortion.

This toolkit includes an article introducing the significance and effects of medication abortion, a protocol of virtual prescribing and consultation from the Society of Obstetricians and Gynaecologists of Canada (SOGC), and a presentation by Planned Parenthood

To see more about resource information, please read the rest of this toolkit.

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Medical abortion is an essential service during the pandemic

Michelle Cohen MD CCFP

Coronavirus disease 2019 (COVID-19) has had a profound effect on our health care system. In primary care, it has stymied the delivery of the preventive and routine services that keep people healthy and out of the hospital. This is no less true of reproductive health care, as evidenced by the 30% increase in calls to Action Canada for Sexual Health and Rights' hotline in late March of 2020.[1] Many callers were distressed by new barriers to contraception or abortion in the wake of the pandemic.[2]

As a family doctor who provides medical abortion services, I am acutely aware of the additional challenges the pandemic poses for reproductive health care. Meeting the comprehensive health needs of patients during these uncertain times requires a wider acceptance of medical abortion in Canadian family medicine and a greater uptake of the mifepristone and misoprostol regimen, known colloquially as the *abortion pill*.

The product combining mifepristone and misoprostol was introduced in Canada in 2017 and hailed as an important advance in equalizing abortion access.[3] The medication is 95% to 98% effective when used at up to 9 weeks' gestation, with common side effects being short-lived bleeding and cramping.[4] Yet, its uptake has been poor in primary care, with more than two-thirds of prescriptions coming from abortion clinics and with many patients reporting that their family physicians refused to prescribe it.[5] Wider acceptance of combined mifepristone and misoprostol in primary care is essential to preserving the reproductive rights of our patients.

Changes in abortion demand owing to COVID-19

For many reasons, the unmet need for abortion during the COVID-19 pandemic might increase.

Difficulty accessing contraception. In March 2020, owing to concerns about drug supply-chain disruptions, the Canadian Pharmacists Association[6] advised 30-day dispensing limits for all prescription medications, a restriction that lasted in some provinces into the summer. These restrictions increased the likelihood of missed doses of contraception. In addition, dispensing medication more frequently meant that patients paid dispensing fees more frequently, increasing the relative cost of using prescription contraception. For people who lost drug benefits owing to the economic downturn, the cost of contraception might also now be prohibitive.

Supply-chain disruptions risk many prescription contraceptives becoming unavailable for unknown periods of time. Shortages in supply can have a cascading effect if demand suddenly increases for the contraceptives still left on the market, much in the way that several recalls of ranitidine in the months before the pandemic led to increased demand and months-long shortages of other acid reflux medications.[7] The global supply chain for condoms was also disrupted by COVID-19, with halted or reduced production prompting manufacturers to warn of impending shortages.[8]

Changes in abortion demand and access. Public health stay-at-home directives have forced many to shelter in place in dangerous environments. Reports of intimate partner violence and child abuse have increased, including rates of sexual assault in the home.[9] As a consequence, we might see an increase in unintended pregnancy. To further complicate an already awful scenario, pregnancy is a well-established intensifier of intimate partner violence.[10-12] In ordinary times, a woman living in an abusive situation could more easily access her support system and her medical providers if pregnancy posed a threat to her safety. During the pandemic, however, the enormous pressure not to go out means that patients cannot access medical care in the same way, resulting in limited options for termination of pregnancy.

At the same time that we could see an increase in unintended pregnancies, abortion services themselves are being restricted. While Canadian health authorities have classed abortion as essential care, some clinics and hospitals have delayed procedures such as intrauterine device insertions and restricted abortion services. Abortion clinics continue to operate, but some have reduced their catchment area.[13] For much of rural Canada, stand-alone clinics are inaccessible, particularly now that the pandemic has made travel more difficult. Travel out of communities to access these stand-alone abortion clinics might result in women having to isolate upon their return, which can present another barrier to access. School and day-care closures present yet another barrier, because most people seeking abortion have children and might now lack child care.[14]

How the abortion pill can help

The mifepristone and misoprostol regimen solves many of the abortion access issues created by COVID-19. The medications can be taken at home, thereby eliminating the need to travel and the many complications associated with travel during the pandemic. The cost of the

prescription is covered by provincial or territorial health insurance and some national programs, so lack of drug benefits should not be a barrier.[15] The tablets can be taken discreetly in unsafe environments and the pregnancy's end passed off as a heavy period or spontaneous miscarriage by anyone facing an abuser's scrutiny.

Unlike surgical abortion, which can involve imaging, multiple visits, and close contact between health care providers and patients, medical abortion generally requires less contact and can be done without imaging in many cases. In April 2020, the Society of Obstetricians and Gynaecologists of Canada (SOGC) released new guidelines for prescribing the mifepristone and misoprostol regimen via telemedicine,[16] which are based on evidence that virtual prescribing and management of medical abortion is safe and effective.[17-20] The SOGC guidelines make these medications a viable option for patients needing a pregnancy termination, while respecting public health guidelines during the pandemic.

Primary care needs a culture shift

One of the important factors in patient access to the mifepristone and misoprostol regimen has been reluctance within primary care to prescribe it. Nearly one-third of all Canadian women will have an abortion, making it one of the most common health services in the country.[21] The view that abortion is specialized, out-of-scope care persists, despite how fundamental a service it is.[22] Medical abortion, in particular, has been hailed as a game changer in Canadian reproductive health care, a way to reverse our problem of extremely uneven access to abortion. The ability to have an abortion without traveling for hours or even days eliminates substantial geographic barriers for rural populations.[23] Primary care providers understand better than most how patients suffer when they cannot access geographically remote services. We should be embracing tools that prevent this type of suffering, especially during the pandemic when the need for abortion might be greater.

Family physicians uncertain about medical abortion should be aware of the resources and supports that exist. The SOGC offers an online course that reviews the basics of prescribing medical abortion as well as the management of complications. Although the course was once mandatory before prescribing combined mifepristone and misoprostol, the requirement has since been removed. The online community Canadian Abortion Providers Support (**https://www.caps-cpca.ubc.ca/index.php?title=Main_Page**) is backed by the SOGC and the College of Family Physicians of Canada and has downloadable resources such as patient handouts, checklists, and electronic medical record templates for primary care providers. An infographic published in early 2020 in *Canadian Family Physician* provides some basic information for both primary care providers and patients. Evidently, there is no shortage of resources to support the successful integration of medical abortion access into primary care practice (**https://www.cfp.ca/content/66/1/42/tab-figures-data**).[24]

Medical abortion is a core primary care service, yet patients' access to this service remains largely limited by the attitudes of many primary care providers. Conscientious objection and anti-choice attitudes among primary care physicians, refusal of clinic staff to clean clinic rooms in which medical abortion is provided, administrator reluctance to implement medical abortion protocol, and pharmacist refusal to dispense are some of the attitude barriers that increase the difficulty for patients to access medical abortion.[25] A culture shift within primary care regarding the provision of medical abortion is needed to realize the enormous potential that the mifepristone and misoprostol regimen has for reproductive health care, including in addressing geographic disparities of abortion services in Canada. Its discreet form, nearly universal Medicare coverage, and prescription accessibility via telemedicine allow it to surmount many of the barriers created by the COVID-19 pandemic. In this environment, family physicians have a duty to protect access to reproductive health care, and that means recognizing the importance of the abortion pill.

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Competing interests
None declared

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CANADIAN PROTOCOL FOR THE PROVISION OF MEDICAL ABORTION VIA TELEMEDICINE

Guilbert E, Costescu D, Wagner M-S, Renner R, Norman WV, Dunn S, Fitzsimmons B, Trouton K, Bernardin J, Black A, Thorne JG, Gomes MA

This protocol aims to describe the provision of medical abortion (MA) in a setting where direct access to abortion providers may be difficult, particularly during a period of social disruption or a pandemic. This protocol may deviate from approved indications or previous clinical practice.

When a request for abortion is received:

1. Confirm patient identity and ensure patient has privacy and safety to discuss
2. Provide written information (for example, by email or fax) on medication and surgical abortion as well as instructions on medication abortion (https://www.shorecentre.ca/wp-content/uploads/NEW-Mifegymiso-Information-Brochure-min.pdf), in advance of consultation
3. If not already done, ask the patient to obtain and take a qualitative urine high sensitivity pregnancy test from pharmacy
4. Schedule a first virtual visit via telephone or video to provide consultation

Pre-abortion assessment via telephone or video (consultation):

1. Review pregnancy options counselling[1]
2. Establish pregnancy and gestational age:
    a. Review date of last menstrual period (LMP), and date of positive qualitative pregnancy test
    b. Review relevant medical history, particularly risk factors and signs/symptoms for ectopic pregnancy and method of contraception used at the time of conception if any
    c. If either intrauterine device (IUD) or intrauterine system (IUS) is present, arrange an ultrasound and appointment for IUD/IUS removal or consider surgical abortion
3. Determine need for an ultrasound;[1-4] obtain an ultrasound and arrange a follow-up visit prior to MA provision if:
    a. LMP is uncertain
    b. LMP is over 70 days ago
    c. Presence of symptoms and signs of ectopic pregnancy[1]
    d. Presence of risk factors for ectopic pregnancy[1]
    e. Presence of an IUD/IUS at any point in pregnancy
4. Exclude contraindications to combination mifepristone/misoprostol medication abortion:
    a. Confirmed or suspected ectopic pregnancy
    b. Chronic adrenal failure
    c. Inherited porphyria
    d. Uncontrolled asthma
    e. Concurrent long-term use of corticosteroid therapy
    f. Haemorrhagic disorder or concurrent anticoagulant therapy
    g. Severe anemia

h. Allergy to mifepristone, misoprostol or other prostaglandins

5. Determine the need for laboratory investigation prior to MA (a 2nd pre-abortion assessment via telephone or video may be required):
    a. Complete blood count is required if suspected severe anaemia or hemoglobinopathy
        i. Hemoglobin should be over 9,5 g/dl before starting MA
    b. Rhesus (Rh) status can be considered if not documented elsewhere (e.g. donor card, previous results) AND if patient would accept Rh immunoglobulins: according to current evidence, Rh testing is required when gestational age (GA) is over 56 days.[5,6] However, during the COVID-19 pandemic, expert opinion recommends that Rh testing may be withheld up to 70 days GA.[7,8]
    c. Sexually transmitted infection (STI):
        i. If the patient must come to the office for any reason, offer screening of Chlamydia and gonorrhea
        ii. If the patient does not have to be seen in person, but there are risk factors for STI, consider remote testing if available, and discuss the potential need for antibiotic prophylaxis (such as Doxycycline 100 mg twice a day for 7 days, starting the same day as mifepristone[1])
    d. Review post-abortion contraception options
    e. Obtain verbal informed consent and document it in the patient's chart[9]

Prescription:

1. Prescribe the following medications:
    a. Mifepristone 200 mg orally and misoprostol 800 mcg buccally or vaginally
    b. Additional dose of misoprostol 800 mcg buccally or vaginally
    c. Analgesics and antiemetics as per health provider/facility protocol
    d. Antibiotic prophylaxis as per health provider/facility protocol, if needed
    e. Contraceptive method
2. Ask patient (or include on separate instructions for pharmacist) to obtain **TWO** high sensitivity urine pregnancy tests from pharmacy
3. Give the following instructions :
    a. The patient should take mifepristone 200 mg orally on a day agreed by the patient and the health professional (document in patient's chart)
    b. The patient should take a first dose of misoprostol buccally or vaginally 24-48 hours after taking mifepristone
    c. **Patients with gestational age 63 days or less** should take the second dose of misoprostol if no bleeding occurs within the first **24 hours after** the first misoprostol dose or as instructed by the clinician[10]
    d. **Patients with a gestational age over 63 days** should take a second dose of misoprostol **4 hours after** the first dose[7,8]
4. Review when to initiate contraception, depending on the method selected[1]
5. Review the instruction sheet with the patient, which include:
    a. Side effects
    b. Warning signs of a complication of a MA (signs of ectopic pregnancy, signs of pelvic infection, hemorrhage, excessive pain)

c. Schedule **follow up #1** and whom to contact for advice or urgent assessment

Follow-up #1 – 7 days post-treatment via telephone or video:

1. Review abortion experience and progress with patient:
    a. Dates of taking mifepristone and misoprostol
    b. Side effects of medication
    c. Bleeding pattern since taking mifepristone and misoprostol
    d. Pain during the process and current pain, if any
    e. Whether or not expulsion occurred
    f. Presence of current symptoms of pregnancy
    g. Warning signs of ectopic pregnancy or infection
2. Advise an urgent assessment or emergency visit if signs of ectopic pregnancy, signs of pelvic infection, heavy bleeding, excessive pain
3. Obtain an ultrasound if history suggests failed abortion or ongoing pregnancy and consider additional dose of misoprostol or surgical aspiration as needed
4. If history suggest successful abortion, no current symptoms of pregnancy, normal bleeding and pain, and no warning signs, instruct the patient to perform a **first** qualitative urine pregnancy **3 weeks from now**, which is 4 weeks after taking misoprostol. Ensure that the patient will have her **first** pregnancy test result available at the time of **follow-up #2**

Follow-up #2 – 4 weeks post-treatment via telephone or video:

1. Review the date **first** pregnancy test was done. Ensure test was performed at least 3 weeks after misoprostol was taken
2. If **first** pregnancy test is negative, reassure the patient that abortion is complete. Do not repeat pregnancy test
3. If **first** pregnancy test is positive, review signs and symptoms of retained product of conception, ongoing pregnancy or ectopic pregnancy:
    a. If present, consider evaluation with ultrasound and/or serum hCGs and:
        i. Retained product of conception: consider additional dose of misoprostol or surgical aspiration
        ii. Ongoing pregnancy: consider surgical aspiration
        iii. Ectopic pregnancy suspected or confirmed: manage accordingly and refer to gynecologist as needed
        iv. Negative ultrasound: consider new pregnancy, have the patient repeat urine pregnancy test (**second**) in one week. Ensure that the patient will have her **second** pregnancy test result available at the time of **follow-up #3**
    b. If no warning signs and no ultrasound: have the patient repeat urine pregnancy test (**second**) in one week. Ensure that the patient will have her **second** pregnancy test result available at the time of **follow-up #3**

Follow-up #3 – 5 weeks post-treatment via telephone or video:

1. Review the date **second** pregnancy test was done. Ensure test was performed 1 week after last (**first**) pregnancy test
2. If **second** urine pregnancy is negative, reassure the patient that abortion is complete.

3. If the **second** urine pregnancy test is positive, in-person urgent assessment with ultrasound and serum hCG is needed, as surgical intervention is more likely to be required. Possible diagnosis at this stage include failed or incomplete medical abortion, pregnancy of unknown location or ectopic, new pregnancy and gestational trophoblastic neoplasia

Contraception provision of long acting reversible contraception:

1. Plan an in-clinic follow-up contact for insertion of implant, IUD or IUS once abortion is deemed completed or according to clinician's advice, and following patient's preference and consent for long acting reversible contraception (LARC).

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Virtual Medication Abortions in Primary Care

Dr. Kaitlin Dupuis

choice is yours.

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Medication Abortions at PPT pre COVID-19

PPT has been offering Medication Abortions (MA) onsite in the CHC since 2018

Pre COVID-19 a client seeking MA would be booked for 3 appointments

1. Initial intake/screening – if moving forward the client would go to a local ultrasound clinic that day to confirm gestational age and that the pregnancy is in the uterus
2. Appointment for the dispensing of medication Mifegymiso
3. Follow up appointment 1 week later to confirm that the pregnancy has been terminated

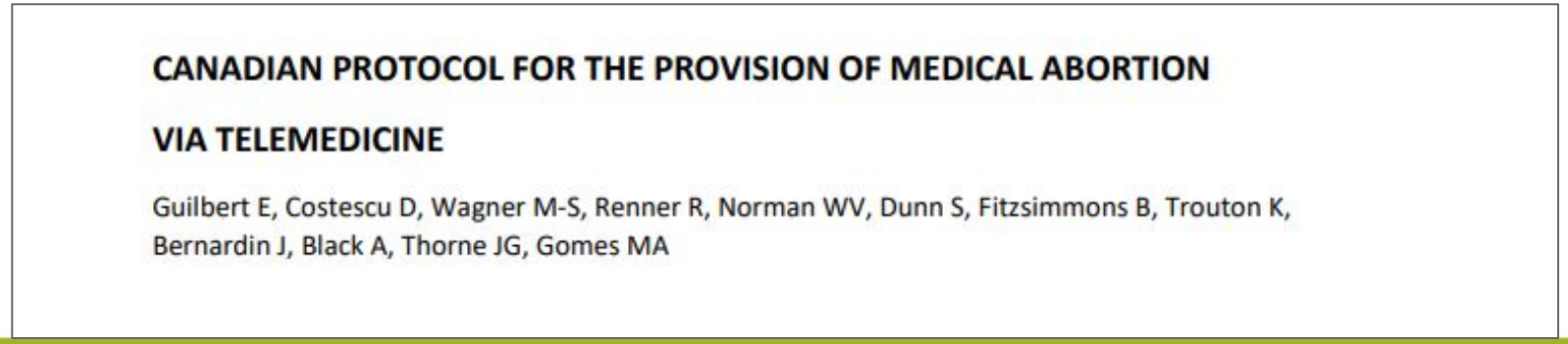
Although very successful, this model of delivery is cumbersome, involves a lot of administrative support and requires the client to be available for several hours and multiple in person appointments.

COVID-19

Across healthcare everyone needed to shift our thinking around how in person care could be delivered virtually

In May 2020 The SOGC endorsed no and low touch medication abortions via telemedicine noting that if appropriately screened and with informed consent clinicians could wave the investigations that were traditionally ordered as part of a Medication Abortion, specifically:

- Screen for ectopic risks with history versus ultrasound
- Waving WinRho administration for Rh- clients instead of routinely offering the product
- Dating the pregnancy based on the clients last known period and regularity of their cycle instead of ultrasound
- Confirm that the pregnancy was terminated using an at home pregnancy urine test instead of bloodwork



CANADIAN PROTOCOL FOR THE PROVISION OF MEDICAL ABORTION

VIA TELEMEDICINE

Guilbert E, Costescu D, Wagner M-S, Renner R, Norman WV, Dunn S, Fitzsimmons B, Trouton K, Bernardin J, Black A, Thorne JG, Gomes MA

What's the research saying?

In the UK 52,142 medication abortions were tracked between January –June 2020, approximately half offered via telemedicine. The researchers found:

- Mean waiting time to obtaining the abortion declined when offered via telemedicine, which further reduced the average gestational age of the pregnancies at the time of the abortion
- Telemedicine was equally effective in terminating pregnancies 98.8%
- Overall incidence of ectopic pregnancy was equivalent in both the telemedicine group and traditional group
- 96% of clients reported "satisfied" or "very satisfied" with their care and 80% reported that they would choose telemedicine in the future as a preferred option

"No-test telemedicine without routine ultrasound for medical abortion up to 10 weeks' gestation is an effective, safe and acceptable service model. Clinical outcomes with telemedicine are equivalent to in-person care and access to abortion care is better…" (p7).

Aiken, A. et al. (2021) Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study. *BJOG* https://doi.org/10.1111/1471-0528.16668

Virtual Medication Abortions at PPT

Intake appointment lasts 30-60 mins by phone or video

- arrangements are made for the client to receive either the medication couriered to their home, pick up at PPT or faxed to their local pharmacy

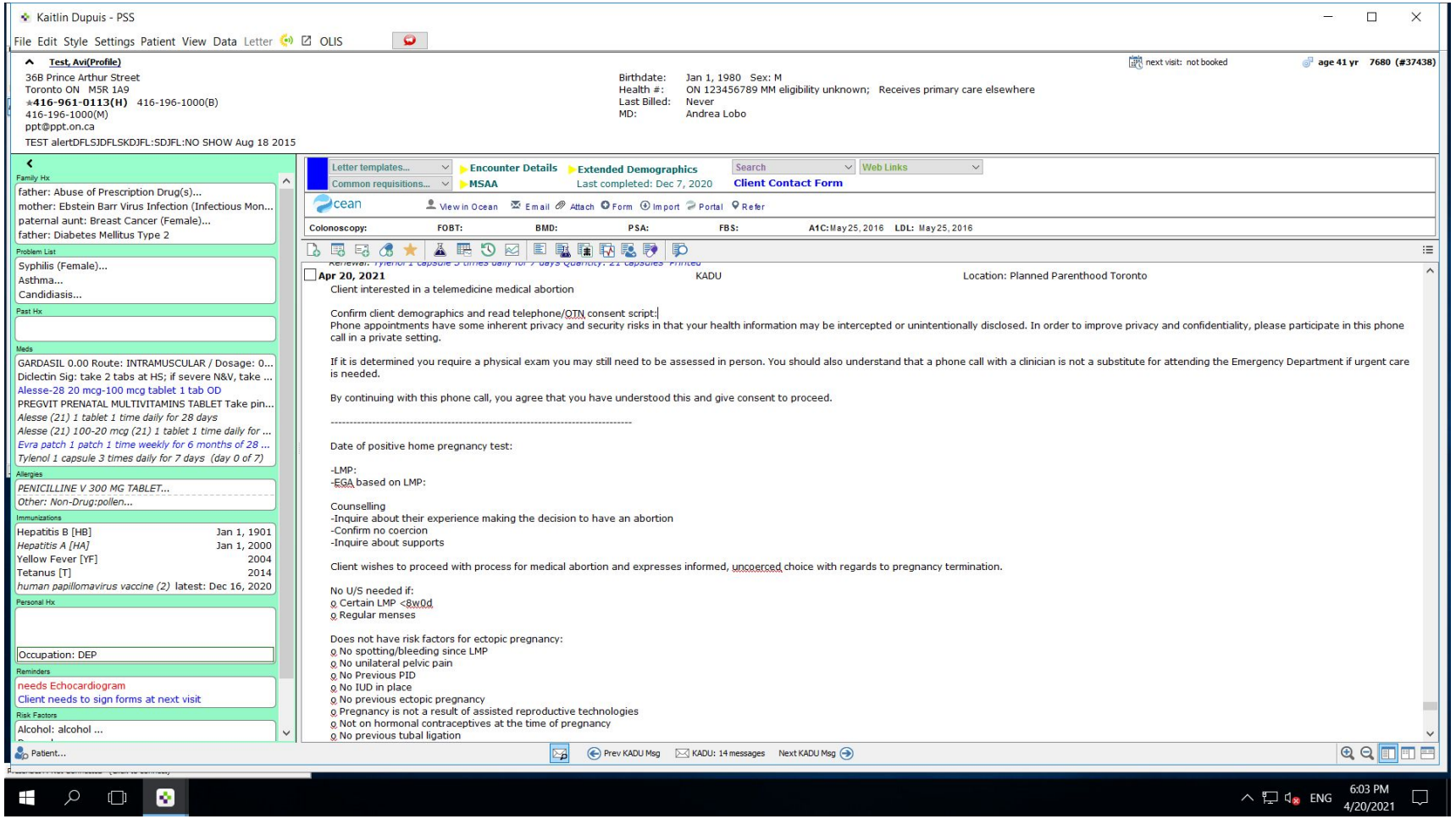
Follow up phone appointment 1 week later

- discuss client experience, follow up on symptoms

Follow up phone appointment 5-6 weeks later

- client has been instructed to take home pregnancy test prior to this appointment to ensure success

Sample First Visit Encounter



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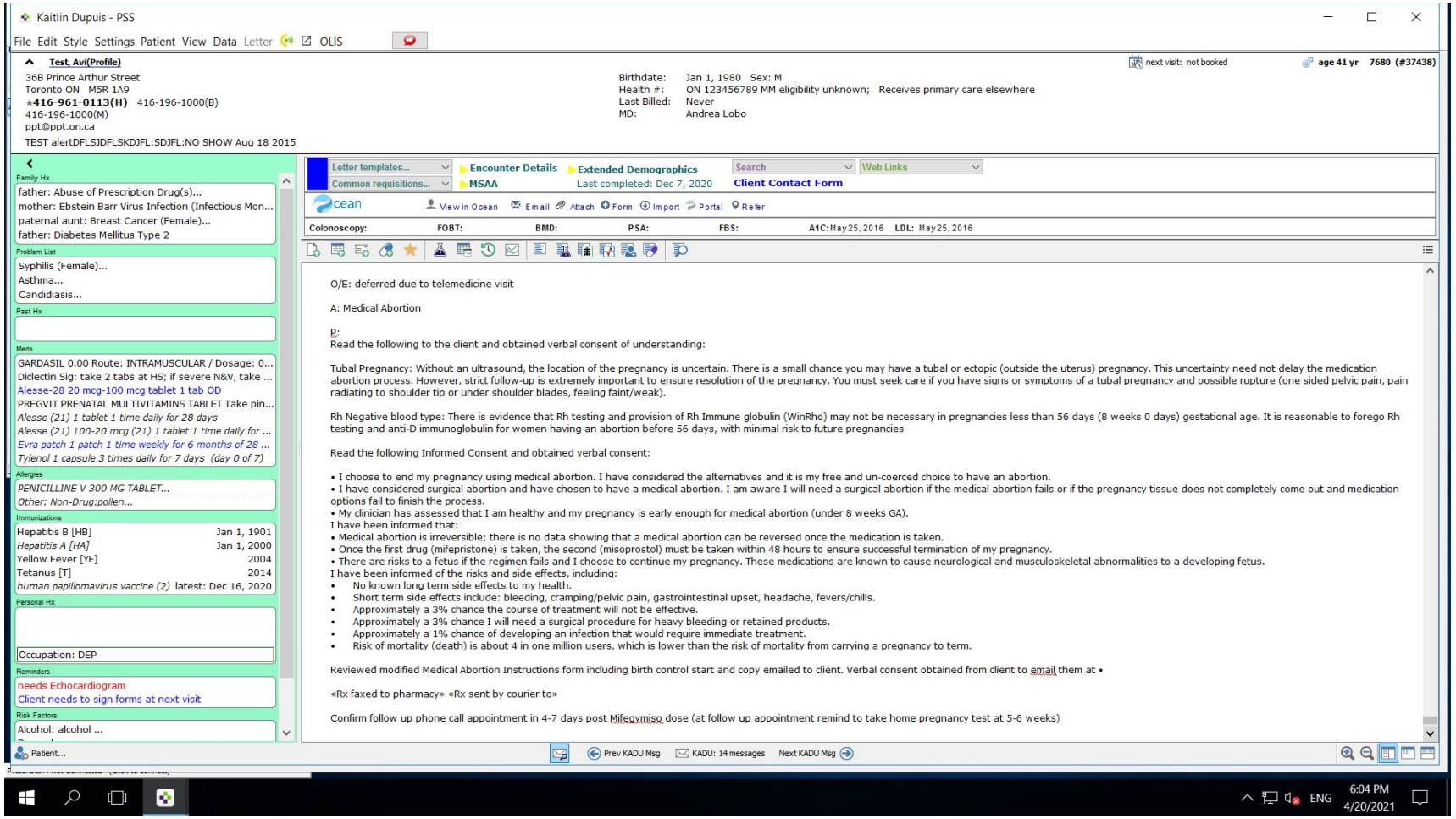
Sample First Visit Encounter



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Client Instructions