WISH COVID-19 Learning Brief #2:

Approaches to support the delivery of self-managed medication abortion during COVID-19

October 2020

Movement restrictions, supply chain disruptions and reduced health facility services associated with the COVID-19 pandemic are affecting women's and adolescent girls' sexual and reproductive health and rights (SRHR) needs, including access to safe abortion services. Self-managed medication abortion (MA) in early pregnancy is an established practice which has become increasingly important in response to COVID-19. As the Foreign, Commonwealth and Development Office (FCDO) Women's Integrated Sexual Health (WISH) programme partners adapt their programmes to continue service provision during COVID-19, this Learning Brief summarises relevant learning from WISH partners and members of the wider SRHR community on self-managed medication abortion approaches during the pandemic. It is written by WISH4Results, the Third-Party Monitoring team for the FCDO WISH Programme.

Key learnings

1) The value of self-management of early medication abortion as a solution to challenges presented by COVID-19 is being recognised to a greater degree than ever, and there is now an opportunity to sustain a rights-based approach to abortion care post-pandemic.
2) Self-management is part of a wider abortion 'ecosystem' and should not be developed vertically as a short-term COVID-19 workaround.
3) Links between health facilities and community-based providers (i.e. other existing organisations, networks, hotlines and platforms, many of which may have supported self-managed medication abortion prior to COVID-19) are critical to support women to access and use medication abortion safely and effectively.

Self-managed medication abortion during COVID-19: Challenges and opportunities

Global health emergencies have a significant indirect impact on sexual and reproductive health and rights (SRHR), by interrupting regular service provision, disrupting supply chains and information provision, and preventing women from accessing facilities to seek family planning and maternal care services. Looking at the potential impact of COVID-19, the Guttmacher Institute has modelled a 10 percent decline in the use of these services over the next year to result in 49 million women in low- and middle-income countries (LMICs) with unmet needs for contraception, and an estimated 15 million unintended pregnancies. With access to many health facilities restricted due to COVID-19, expanding self-care approaches to strengthen access to safe abortion is an option for both government and non-governmental SRHR programmes to consider, and a critical avenue for averting unsafe abortion (see Box 1 for definitions).

Box 1: Key terms in relation to self-managed medication abortion

This Learning Brief focuses on self-management of medication abortion in the first trimester (also referred to under the broader umbrella of self-care innovations) in the context of COVID-19.

- **Self-care** is the ability of individuals, families, and communities to promote and maintain health with or without the support of a healthcare provider. Effective self-care with safe links to healthcare systems can potentially improve health.
- **Abortion self-care**, or **self-managed abortion** is termination of pregnancy using pharmacological drugs – known as **medical** or **medication abortion**, or **MA** – (either using a combination regimen of Mifepristone and Misoprostol, or a Misoprostol-alone regimen), with a woman managing as much of the process as she wants on her own and involving a health provider when she chooses to.

Self-care approaches to abortion can empower women by allowing them to manage their abortion in the comfort and privacy of their own home, removing financial burden and stress in countries where abortion is not culturally accepted. Self-care removes the need for women to travel long distances to access clinics for abortion services – addressing transport and cost barriers which are particularly acute among women living in poorer communities, and in the context of COVID-19 supporting access to abortion where movement restrictions are place and facility-based services may be restricted. These approaches rely heavily on the availability of quality MA commodities.

This brief focuses on the self-management of **MA in the first trimester**, where medication abortion takes place up to 12 weeks of pregnancy.

Despite the recent COVID-19-related interest in self-care, self-managed early medication abortion (MA) is not a recent innovation. The WHO's 2015 guidance on Health Worker Roles in Providing Safe Abortion Care and Post-Abortion Contraception refers to self-managed Misoprostol use at home as a safe option that also decreases staff and facility utilisation, and enables services to be provided at lower levels of the health system closer to women's homes. The full potential for self-managed MA is being brought to light by the pandemic, and in some countries policy and legal barriers to self-managed MA access have changed. Demand for abortion products is likely to grow as countries experience slowdowns in family planning availability and uptake due to COVID-19 disruption, as well as health facility closures. This creates an opportunity to work within respective countries' legal frameworks to improve relevant regulation, affordable access channels and information on self-managed MA.

However, while the current circumstances of COVID-19 have created an environment in which support for self-care (including MA and contraception) is growing, several challenges have emerged. Manufacturing and supply chains have been negatively affected by lockdowns, with major delays caused by the limited capacity of ports. Marie Stopes International (MSI) and DKT International reported significant backlogs in the manufacture of key commodities as production ceased or was reduced during lockdowns. Movement restrictions also created challenges for MSI's staff and distributors to reach warehouses and ensure stock reached service delivery points. Without national-level prioritisation during the COVID-19 crisis, health workers supporting family planning and SRHR service delivery in some countries have been re-assigned to COVID-19 care, weakening existing pathways to self-managed MA. COVID-19 has also limited physical travel, hindering face-to-face engagement opportunities with health workers and pharmacists for sensitisation and training on how to support self-managed MA. Similarly, advocacy efforts with policymakers on the

legal status of MA have been limited by the pandemic, as key stakeholders' attention has shifted to mitigating the immediate impacts of COVID-19.

Adapting self-managed medication abortion during COVID-19

Follow guidance on what is clinically necessary for a successful abortion

For women in some country contexts, medical procedures which may be clinically unnecessary – such as ultrasounds, Rh testing and anaemia testing – are required to access MA. Particularly in the context of minimising contact between clients and health providers during COVID-19, programmes should adhere to the existing globally agreed guidance on this topic. The WHO's 2018 guidance on Medical Management of Abortion states that ultrasound scanning for gestational age or overall provision of abortion is not routinely required. Rather, last menstrual period (LMP) calculations can determine gestational age and be used outside of facility settings to confirm gestational age. These guidelines also outline the contexts in which self-administration of abortion medications are recommended – i.e. in settings where women have a source of accurate information, quality products are available, and access to a healthcare provider is available if it is wanted or required during any stage of the process. With these conditions, WHO recommends that the abortion process using a combination regimen can be successfully self-managed for pregnancies below 12 weeks of gestation without direct supervision from a healthcare provider.

Ensuring access and linkages to facility-based care

Promoting and expanding access to self-managed MA may be a practical option for SRHR programmes looking to mitigate the impact of COVID-19 on safe abortion services. For programmes adapting towards self-management of MA, linkages to existing health facilities for women are critical in order to underpin a rights-based approach. WISH partners caution that the binary view of health system-based care and self-managed care does not reflect the reality of most women's pathways to abortion care. Rather, many women may begin self-managed MA at home, for example, and then connect with health providers for follow-up care or after experiencing side effects or warning signs of possible complications as part of their continuity of care. Many may want reassurance that their abortion is complete, and that their reproductive health will not face long-term consequences. In countries where abortion access is restricted, it is crucial to carefully foster links between self-care and health systems so women are not deterred from seeking post-abortion care where necessary. Programmes should be able to direct women towards accurate information and care and offer confidential, safe, and rights-based care (one example is detailed in Box 2).

Box 2: Blending self-care and facility-based care - Ipas

Many women who choose self-managed abortion at home may need or want to go to a facility at some point. Ipas' work aims to create bridges between self-care and facility-based care by rooting its self-managed abortion programmes in partnerships with referral facilities with trained health providers. When women are given MA supplies, they are also informed about the signs which indicate when they should seek additional care, and where to go for this.

To support self-management of MA, Ipas engages providers to ensure quality and continuity of care. Ipas abortion self-care values clarification and attitude transformation (VCAT) workshops help health providers and key stakeholders re-conceptualise what self-managed abortion is, and better understand why women may opt for or prefer this approach over facility-based care. This encourages facilities and providers to act as positive points of care (e.g. ensuring confidentiality and focusing on care and support for women rather than criminalisation) within the overall continuum of care, as well as developing policies and guidance which support women's best interests.

Under its 'accompaniment model' Ipas trains community members to support women who opt for self-care with accurate information, guidance, and support when it is requested. Accompaniment persons can also help women with referrals to health care facilities when needed. To support this, Ipas has developed materials directly for women, including videos and information cards (pictorial and low literacy) on what to look for when purchasing MA pills, how to take the pills and other key guidance. The simple, accurate and evidence-based information supports women in the self-management process.

Source: Interview 30/06/2020

Access to MA through online telemedicine services (health services provided via information and communications technology) is an established way of delivering MA pills to women . The access barriers to clinic-based consultations for MA presented by COVID-19 can potentially be overcome by adapting care pathways to include telemedicine components. During COVID-19, MSI has provided telemedicine services for self-managed MA in the UK and South Africa. At MSI's existing contact centres, staff counsel and support women through their self-care choices, and facilitate the delivery of MA pills to women's homes or a nearby pharmacy. The potential to use telemedicine varies between countries depending on the barriers experienced by women accessing services, and the legal and regulatory context on telemedicine and SRHR.

Supplementing pharmacy staff capacity for provision of medication abortion

In the context of COVID-19 where facilities' capacity may be limited, pharmacies can play an important role in providing MA medication to women.

While simple adaptations to pharmacy-based delivery may support product delivery during COVID-19, other measures may be needed to strengthen this channel. An evidence summary by MSI brings together information on self-managed MA provided by pharmacies. It highlights evidence that pharmacy provision of MA is safe and effective when genuine, quality-assured drugs are available and accurate dosage is provided, and when users have access to adequate information and access to follow-up support where needed. However, the brief also presents evidence that improvements to pharmacists' knowledge on MA do not necessarily result in improved counselling or information provision, and which can be further limited by factors such as short consultation times, negative attitudes, lack of privacy and

confidentiality and high staff turnover. Pharmacy provision of MA should therefore be considered within a range of other interventions as part of a wider, supportive 'ecosystem' – for example, user-friendly product labelling, signposting to hotlines, digital platforms and community health networks can also be used to assist women seeking self-managed MA.

Improved information channels

With community sensitisation activities constrained or halted due to COVID-19, there is a critical need for information sharing on the availability of MA and signposting to where women can access information, counselling and supplies. To facilitate use of MA there are globally-trusted websites, for example HowToUse; hotlines across the globe or telemedicine platforms which are widely-accessible, socially-distanced and reliable interventions.

MSI emphasises that while product quality is the most important factor for the safety of self-administered MA, safety can be strengthened with appropriate information (see section on quality, regulation and availability of medication, page 7). Particularly in the context of COVID-19, concurrent efforts to facilitate women's direct access to information and trained support are critical. These include availability of quality products in the appropriate dosages, strengthened product packaging, links to contact centres, hotlines and digital information (see the next section).

Considerations for adapting self-managed medication abortion programmes during COVID-19

This section highlights considerations programmers may wish to think about when adapting self-managed MA programmes to the context of COVID-19.

1. **Use what is available**

SRHR providers may be hesitant to prescribe MA pills to women without examining them and performing an ultrasound. In response, low-tech adaptations and 'tweaks' to services which harness available resources and personnel can encourage the continuity of medication abortion provision during COVID-19. For example, behaviour change work, sensitisation on existing WHO guidance and support to recalibrate health providers' skillsets for the COVID-19 context may provide women with smoother access to self-managed abortion. Additionally, Gynuity's latest guidance emphasises the skills and methods that providers can use to confirm pregnancy and gestational age without clinical screening or laboratory tests such as a quick (urine) pregnancy test or estimate of the first day of one's last menstrual period (LMP).

The International Federation of Red Cross (IFRC), WHO and UNICEF recommend that where access to health facilities is reduced, health authorities support trained community health workers to provide SRHR counselling and information, using digital decision support tools where available and appropriate. Accompaniment networks or other arrangements (hotlines, doulas and birth attendants) could help women navigate accessing self-managed medication abortion and supportive care, while providing discretion in contexts where abortion is highly stigmatised. For example, MSI's contact call centre workers are trained and scripted to provide support on dosage, warning signs and emergency referrals for women who purchase MA products from pharmacies or other outlets.

2. **Expand self-managed abortion as part of the wider 'ecosystem'**

During COVID-19, self-managed MA has emerged as a key way to ensure access to safe abortion and post-abortion care for women – maintaining service continuity and freeing up

facilities' capacity and resources to provide COVID-19 care. However, self-management is not the only option, and outpatient clinic-based primary care services may be both needed and/or preferred, particularly in the case of termination of pregnancies beyond 12 weeks. A predominant focus on delivering self-managed abortion services may risk developing this approach in isolation from the wider health system. A balanced approach is required, linking self-management to health system-based care at appropriate points in the care pathway. Tools such as PSI and partners' Quality of Care (QoC) framework for self-care may be relevant to these efforts.

Current efforts to expand self-managed MA access should not detract focus from longer-term country-level advocacy for universal access to quality, safe abortion services. More generally, an enabling environment for MA should address human resources factors where health system links are made, such as provider training on new products, cascading tasks and skills into training, with guidelines and aids. Linkages with the private sector and robust supply chains, licensing and packaging are also important – as well as considerations for equitable access among people living with disabilities, adolescents and people living in poverty, including low literacy populations, along with translation into local languages.

3. Document approaches

The COVID-19 pandemic has led to a break in 'business as usual' for SRHR programmes, including greater focus on self-managed abortion interventions. In so doing, the situation provides an opportunity to generate evidence to better understand how self-management of abortions works on a large scale and its ability to meet women's needs. Innovative approaches developed during this period should not only be limited to life under COVID-19. Rather, programmes should document what is working and what is not, with a view to scaling up promising approaches and practices, and sharing learning with other implementers. Lessons and abortion trends from previous disease outbreaks such as Ebola and Zika could also be integrated into future learning.

4. Face-to-face engagement

Movement restrictions introduced to contain the spread of COVID-19 have severely limited the engagement efforts of SRHR programmes, upon which self-managed abortion access often depends. Face-to-face engagement and outreach are often required to introduce new ideas and approaches at a distance; shift national and local health stakeholders', providers', pharmacists', or community-based health actors' attitudes around abortion, and for them to understand the increased demand for self-management during a pandemic. In contexts where abortion is stigmatised, women may need counselling and encouragement before talking about their requirement for an abortion. Getting the pills to clinics and pharmacies alone is therefore not enough to encourage women's use of MA. Programmes that support the self-management of MA should therefore integrate opportunities to engage with women, men and community leaders when working in these contexts, and physical outreach (while adhering to social distancing and infection prevention and control requirements) where possible.

5. Quality, regulation and availability of medication

Quality products are critical for self-management of MA. The WHO recommends that for successful self-managed early MA, regulatory agencies must ensure quality products are available in adequate quantities and appropriate dosages. However, in the context of COVID-19, production and supply chain disruptions may limit the availability of preferred medication regimens and quality-assured products. Recognising the wider and more general challenges of getting quality-assured MA commodities to market, FCDO have worked with

the Reproductive Health Supplies Coalition (RHSC) on market-shaping initiatives to support low-cost MA product manufacturers to become quality-assured and register in-country.

The ability to provide and adapt self-managed MA as part of SRHR programme may be constrained by what medications are licensed and available in different countries. Distribution channels will also vary depending on availability and licensing. Therefore, appropriate and correct information for the different types of medication regimens (e.g. Misoprostol-alone, or combination packs of Mifepristone and Misoprostol) must be provided to women upon receipt.

Resources for self-managed abortion programmes

The following online resources provide information and guidance for self-abortion programmes during COVID-19:

- Gynuity – Guidance for Providers Offering Misoprostol-Alone for Abortion Amidst COVID-19 (2020).
- International Federation of Gynecology and Obstetrics (FIGO) – Statement on Abortion Access and Safety with COVID-19 (2020).
- International Federation of the Red Cross, World Health Organization and UNICEF – Community-based Health Care, Including Outreach and Campaigns, in the Context of the COVID-19 Pandemic (2020).
- Ipas
    - Resource Library
    - Informational videos on self-management of medication abortion (Spanish/English)
- IPPF, Gynuity and Concept Foundation – Medication Abortion Commodities Database
- Population Services International (PSI) – Quality of Care Framework for Self-Care
- Reproductive Health Supplies Coalition – Safe Abortion Supplies Workstream
- SafeAccess – SafeAccess Hub
- World Health Organization –
    - Maintaining essential health services: operational guidance for the COVID-19 context (2020).
    - WHO Consolidated Guideline on Self-Care Interventions for Health (2019).
    - Medical management of abortion (2018).
    - Health worker roles in providing safe abortion care and post-abortion contraception (2015).
    - Safe abortion: Technical and policy guidance for health systems (2012).

Further information

About the WISH Programme
The WISH Programme is the UK's flagship and largest Sexual and Reproductive Health and Rights (SRHR) delivery programme, delivering up to 20% of the UK's overall commitment to improving global SRHR. WISH, implemented in two lots led by different consortia, operates in 27 countries in Asia and Africa and is expected to contribute to averting over 29,000 maternal deaths by December 2021.

The WISH4Results team, composed of staff from the e-Pact consortium – Itad and Oxford Policy Management – acts as the third-party monitor for the WISH programme, providing verification, evidence and learning for FCDO, WISH implementing partners and wider stakeholders.

FCDO's policy position on safe abortion
The UK's Foreign, Commonwealth and Development Office (FCDO) supports women and adolescent girls' rights to their own decisions on sexual and reproductive health and wellbeing, and being able to choose whether, when and how many children to have. FCDO does not support abortion as a method of contraception. In countries where abortion is permitted, FCDO supports programmes that make safe abortion – which reduces recourse to unsafe abortion, saving maternal lives – more accessible. In countries where abortion is highly restricted and maternal mortality and morbidity are high, FCDO can help to make the consequences of unsafe abortion more widely understood and can support processes of legal and policy reform.

About WISH COVID-19 Learning Briefs
The COVID-19 pandemic is likely to have severe impacts on access to sexual and reproductive health and rights (SRHR) services for all people but for women and adolescent girls especially. The WISH programme's implementing partners, WISH4Results and global health partners are collaborating to capture learnings and rapid adaptations to SRHR service delivery in order to maintain vital access to rights-based, high-quality care.

This publication is one of a series of Learning Briefs produced by WISH4Results focusing on adaptations to SRHR delivery driven by the COVID-19 pandemic. Drafting and editing was led by Pippa Page, with support from other members of the WISH4Results team. Content was compiled through a series of semi-structured interviews and follow-up emails with representatives from the organisations listed below. We are particularly thankful to members of the WISH COVID-19 Technical Working Group for their insights into the challenges of and need for remote training during COVID-19 and specifically to the following organisations who contributed information to this brief:
Asia Safe Abortion Partnership (ASAP)
Gynuity
Ipas
International Planned Parenthood Foundation (IPPF)
Marie Stopes International (MSI)
Reproductive Health Supplies Coalition (RHSC)
UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP)

Please share your feedback and comments on the materials discussed in this brief, contribute related resources and discuss other adaptations to SRHR remote training by emailing WISH4results@itad.com.

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