Making Abortion Safe

RCOG's global initiative to advocate for women's health

Royal College of Obstetricians & Gynaecologists

Best practice in telemedicine for abortion care

Published by the Royal College of Obstetricians and Gynaecologists, 10–18 Union Street, London, SE1 1SZ, UK.

www.rcog.org.uk

Registered charity no. 213280

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Contents

Introduction to RCOG Best Practice Papers

The Royal College of Obstetricians and Gynaecologists (RCOG) Best Practice Papers are peer-reviewed, easy-to-use, adaptable documents that set out the essential elements for evidence-based clinical practice.

The best practices described are drawn from evidence-based guidance produced by organisations such as the World Health Organization (WHO), the Faculty of Sexual and Reproductive Healthcare (FSRH), and the National Institute for Health and Care Excellence (NICE).

To be readable and useful to people providing healthcare daily, the papers have been deliberately kept short and succinct. Therefore, the primary evidence for recommendations and the strength of that evidence have been omitted but can be found in the original source documents. Very recently published evidence has been assessed to determine whether any recommendations from current guidelines should be amended.

The recommendations may also be used as a tool to assist policy makers in improving services.

While Best Practice Papers may be used for reference in any country, local policy and service-delivery contexts may require adaptation of some recommendations; however, it is important to ensure that evidence-based practice is maintained.

For support on adapting the document while maintaining good practice, please contact cfwgh@rcog.org.uk.

Language note

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

RCOG guidance disclaimer

The RCOG produces guidance as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians, gynaecologists and other relevant health professionals.

It is healthcare providers who must make the ultimate judgement about a particular clinical procedure or treatment plan in the light of clinical data presented by the patient, and the diagnostic and treatment options available. Therefore, RCOG guidance is unlike protocols or guidelines issued by employers because they are not intended to be prescriptive directions defining a single course of management.

Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's clinical notes at the time of the relevant decision.

www.rcog.org.uk/guidance/rcog-guidelines-disclaimer/

Acknowledgements

This Best Practice Paper was developed by Sharon Cameron, Michelle Cooper and John Reynolds-Wright and was peer reviewed by Patricia Lohr, Rebecca Gomperts, Angelina Namiba, Kristina Gemzell -Danielsson, Joseph Adu, Abigail Aiken, Beverly Winikoff, Daniel Grossman, Munyaradzi Nyakanda, Ernest Nyamato, and Jayne Kavanagh.

It was produced as part of the RCOG Making Abortion Safe programme – a 3-year programme working to increase healthcare professionals' capacity to address the barriers to safe abortion care and/or post-abortion care, globally. For more information visit www.rcog.org.uk/en/global-network/centre-womens-global-health/our-work/making-abortion-safe/

Acronyms and abbreviations

hCG	Human chorionic gonadotrophin
IUD	Intrauterine device
LARC	Long-acting reversible contraceptives (IUDs and progestogen-only implant)
LMP	Last Menstrual Period
NICE	National Institute for Health and Care Excellence
POP	Progestogen-only pill
RCOG	Royal College of Obstetricians and Gynaecologists
STI	Sexually transmitted infection
WHO	World Health Organization

Background

This Best Practice Paper provides guidance on the provision of abortion care by telemedicine based on the evidence available. There is much evidence from the UK to support best practice delivery of abortion care in this way, as well as from parts of the USA, Australia and Canada. There is also more than a decade's worth of extensive evidence – from organisations such as Women On Web, Women Help Women and Safe to Choose – on the use of telemedicine to deliver safe abortion care outside the formal healthcare setting to global settings where abortion is restricted.

The WHO, RCOG and NICE guidelines on abortion care all support the use of telemedicine for abortion.

Best Practice Papers are aimed at staff providing healthcare on a daily basis, trainees and medical students, and advocates and policymakers looking to move their services forward. This Best Practice Paper focuses on one aspect of delivery of abortion care and is designed to be read in conjunction with the other Best Practice Papers on provision of abortion care.

What is telemedicine for abortion care?

Telemedicine can be defined as the use of information and communication technologies to improve patient outcomes by increasing access to care and medical information. Using a telephone, video call or the internet can allow those who need an abortion to have all, or part, of their care at home, with remote support during and after treatment from the abortion provider.

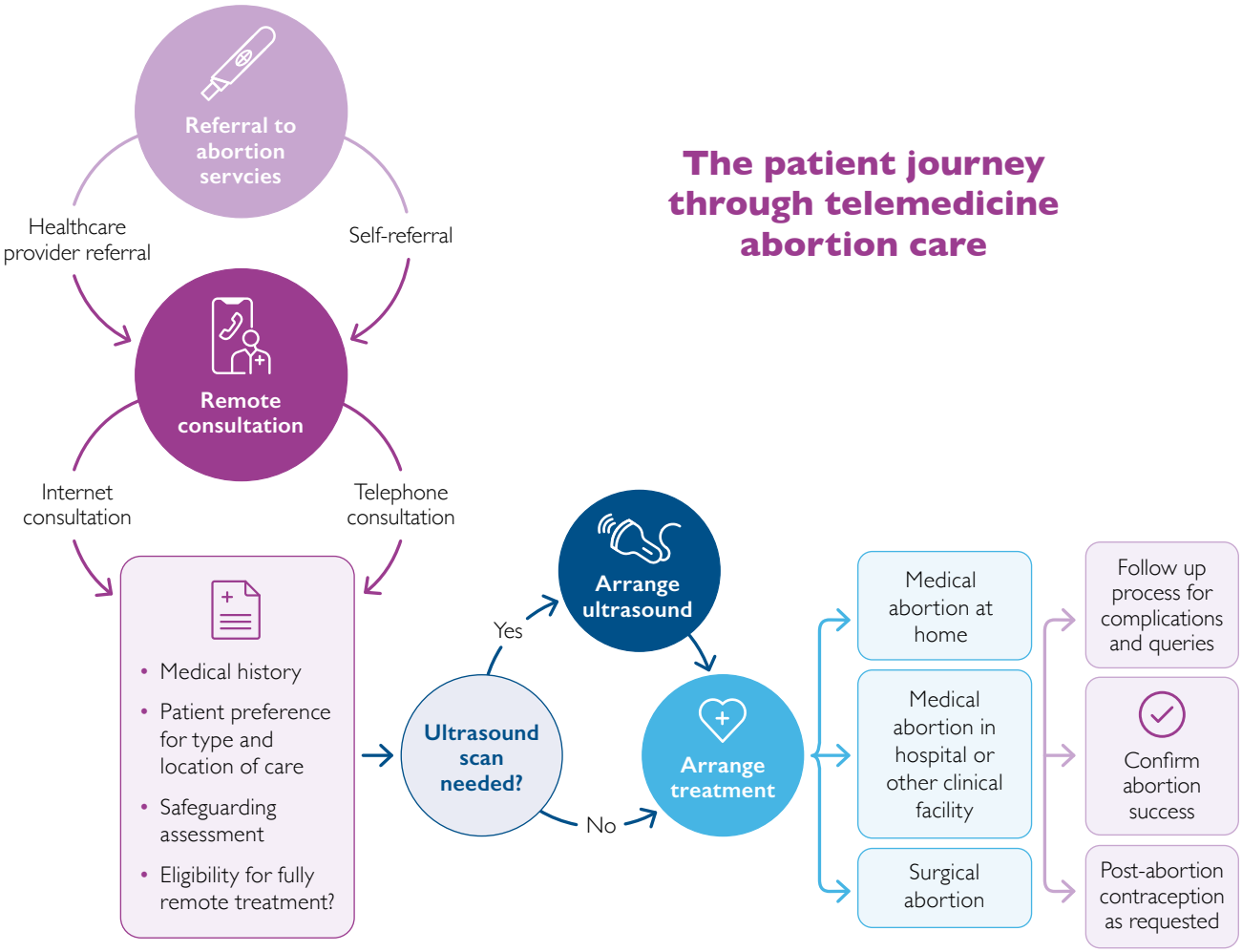
Telemedicine can be used to deliver elements of abortion care including the provision of information and decision-making support; medical consultations for abortion; provision of abortion medications, contraception and tests for sexually transmitted infections (STIs); and support for the management of medical abortion at home. It can also be used to provide post-abortion care.

Abortion registry data from the UK and the USA shows that when telemedicine is used in abortion care, it is associated with medical abortions taking place earlier in the pregnancy. This indicates improved access which, is important since abortions at earlier gestations are better tolerated and associated with a lower risk of complications or likelihood of failure.

The option of having a consultation via telemedicine helps reduce logistical and financial barriers to accessing care that would be imposed by requiring a visit to a clinic. These barriers include transport difficulties and expenses, employment or caring responsibilities, disabilities, young age, and living in remote communities. Research has shown that patients value the privacy, convenience, and autonomy that a consultation by telemedicine offers.

In the UK, telemedicine was used to deliver medical abortion during the COVID-19 pandemic. Evidence from this period demonstrated that a 'no test' model of care, in which ultrasound was only used when clinically indicated (to confirm gestation or exclude an ectopic pregnancy), is safe, effective and acceptable to women. Research among women and healthcare workers also showed that making telemedicine available as one way to deliver medical abortion provides a patient-centred approach to care (see Figure 1).

Figure 1 Patient pathway through telemedicine abortion



Digital technology

While an in-person consultation is not essential to the provision of abortion, it is important that choice is maintained. Anyone who prefers an in-person consultation should be offered one. In addition, in-person consultations should be available for those do who not have telephones, internet access, or the ability to use digital technologies effectively or confidentially. If telemedicine applications (apps) or websites are used to collect patient data, then these should be secure and confidential, in line with data protection and privacy laws and cybersecurity protocols.

Who can provide telemedicine for abortion?

The WHO and RCOG recommend that abortion care – particularly medical abortion – can be improved by expanding the range of healthcare professionals who are able to deliver it, including nurses and midwives.[1] This also applies to telemedicine for abortion. Telemedicine can help multidisciplinary teams to deliver safe abortion care because it can add flexibility to remote working arrangements and expand geographical reach to specialist doctors if required. In addition, in some legal frameworks (such as the UK) where only doctors may prescribe medical abortion pills, telemedicine may facilitate remote prescription, whereby a clinical record completed by another healthcare professional, such as a nurse or midwife, may be reviewed remotely by a prescribing clinician. Thus, telemedicine can be used to maximise skills and task-share within the multidisciplinary team.

[1] https://www.rcog.org.uk/media/geify5bx/abortion-care-best-practice-paper-april-2022.pdf

Supportive information around telemedicine for abortion

The availability of telemedicine for abortion care should be advertised so that people know how to access abortion care in this way. High-quality supporting information about abortion care should be available in advance of the telemedicine consultation, and this should be easily accessible. This information should be understandable to all people needing abortion care; for example, it should be available in different languages and formats, such as written and audiovisual. Research shows that web-based information including animations to demonstrate what an abortion consultation involves, and how to manage medical abortion at home, is an effective and acceptable way to deliver supportive information to patients seeking an abortion.

There should never be a requirement for compulsory counselling or mandatory time for reflection before an abortion. However, women and pregnant people should have access, if they require it, to counselling and decision-making support about their pregnancy options. These can be delivered using telemedicine modalities, but the option of an in-person visit for counselling should also be available.

Abortion consultation by telemedicine

Facilitating respectful communication and developing trust

At the telemedicine consultation, the health worker should approach patients with a friendly, open manner. If the consultation is by telephone or video call, the health worker should first confirm that they are speaking to the correct person and that the patient was expecting the call. Patients should be asked if they are in a private area, alone, and/or can talk freely, and the health worker should explain the reason for the call, before confirming that the patient wishes to proceed with the call.

Introductions should include the health worker's role and name, and if any other health workers are present or listening in on the consultation as part of training in abortion care, then permission should be sought from the patient for this, and the name and role of those health workers provided. The health worker should also explain how the consultation will proceed, including an estimated duration. Patients should be invited to ask questions and to ask for further clarification if needed.

Exactly as for an in-person consultation, health workers undertaking a telemedicine consultation should be aware of:

- anxiety the patient may have about perceived negative and judgemental attitudes from healthcare professionals
- the effect that verbal and nonverbal (if video) communication may have on patients.

Health workers can help relieve anxiety, create a safe and respectful space, and counteract abortion-related stigma by:

- introducing themselves, explaining what the consultation will entail, and conveying that they are there to support the patient's wishes
- making eye contact and smiling (if the telemedicine consultation is being conducted by video call)
- using welcoming words and building rapport before exploring the patient's feelings about the pregnancy
- explaining the structure and content of the consultation to help support and manage the patient's expectations
- giving clear, concise, accurate information and encouraging questions

- trying not to make assumptions and using value-neutral, unbiased language
- conveying how common abortion is and encouraging patients to talk to someone they trust.

If the health worker is unable to reach the patient, then they should leave a message, if the patient has given permission for this. The message should indicate that they have attempted to contact the patient and how to reschedule a call if the patient wishes this. In a voicemail message, it is important not to use words that might make it obvious to a third party that the patient has been seeking abortion care.

If a health worker feels that the connection quality of the call or video is too poor to proceed, then the patient should be given the option to reschedule (without unnecessary delay), or to attend an in-person consultation, if this is preferable and possible for them.

Safeguarding assessment

As with in-person care, all patients receiving telemedicine abortion care should undergo a safeguarding assessment, and this should essentially be conducted in the same way as a safeguarding assessment at an in-person visit. In fact, some individuals might find that they can speak more freely during a telemedicine consultation and therefore be more willing or able to divulge details of abuse.

For telemedicine consultations by telephone not involving video, health workers should remain alert for any verbal cues that might raise concern about the patient's safety. The consultation should include routine questions about coercive behaviour of partners, family members or other people, and experience of physical or emotional abuse. Patients disclosing safety issues should be signposted or referred to appropriate agencies for support. The assessment should also consider whether the patient has existing children that may be at current risk of harm and, if so, they should be referred to child protection services.

A robust safeguarding assessment should be given to vulnerable people, such as girls or young women not of adult age; those with disabilities or special needs; and substance misusers who may be at particular risk of forced sex, exploitation and harm. An individualised approach should be taken to determine their level of understanding of abortion, social circumstances and existing adult support network.

Abortion services should have a system for patients to subtly alert staff during a telemedicine consultation to safety issues without patients having to directly voice their concerns. For example, when patients make initial contact with the service, patients could be advised about use of a 'safe word', which – if used by the patient during the telemedicine consultation – will trigger staff to arrange an in-person visit for further assessment.

Providers should never withhold the option of a telemedicine consultation from a patient based on age or disabilities alone. Wherever possible, individuals should be supported to have a telephone/video consult if this is their preference. This may require use of a confidential interpreting service, or the presence of a trusted supportive adult or social worker if the patient is very young or vulnerable.

Determining pregnancy duration

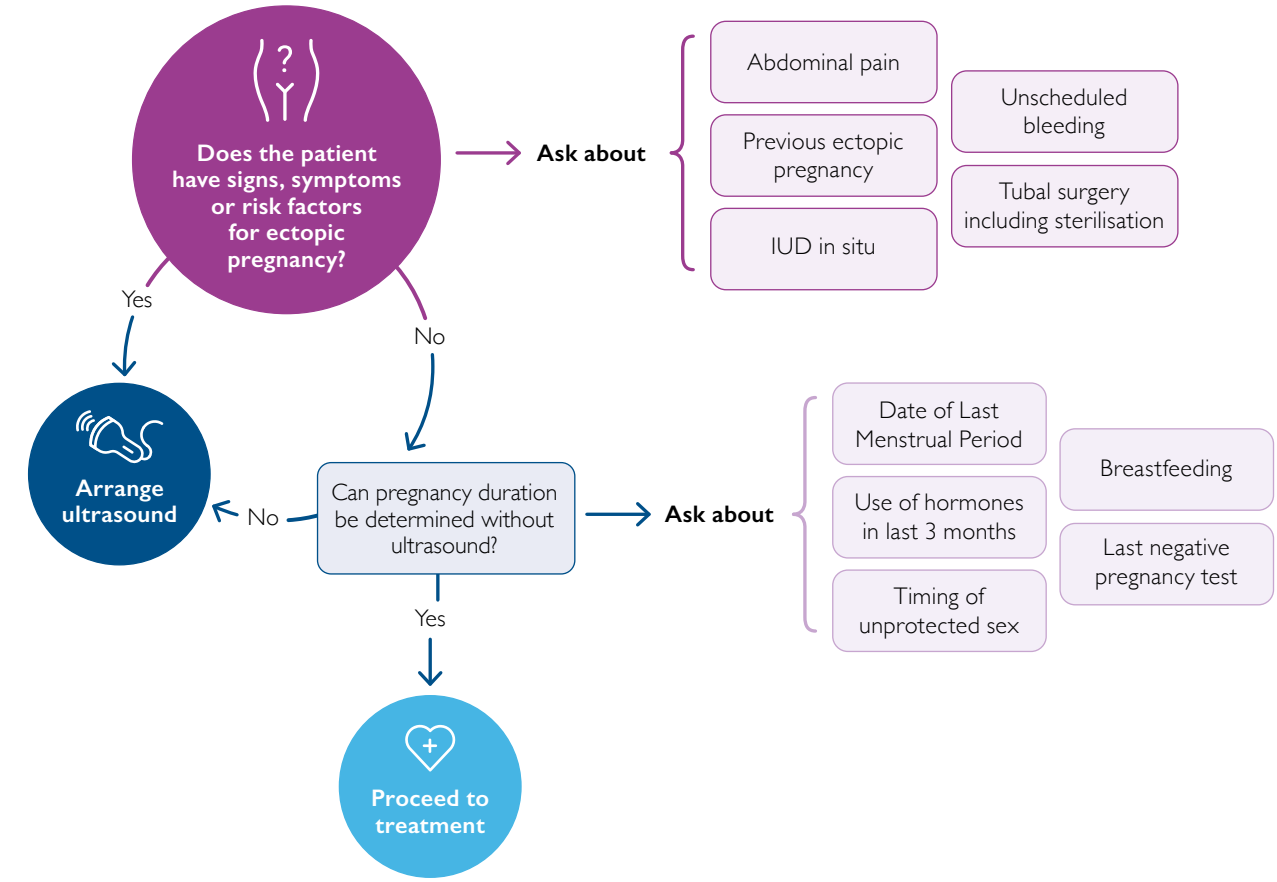
The duration of the pregnancy will influence the method of abortion, and whether the abortion can take place at home or in a clinical facility.

Most people can determine the duration of their pregnancy with reasonable accuracy using the first day of their Last Menstrual Period (LMP). Gestational assessment based on LMP alone should include enquiry about whether periods are regular (every 25–35 days), and if the last period was normal for them in timing, duration and quantity. This allows the health worker to be alert to the possibility that the 'last period' might actually have been an implantation bleed, suggesting that the pregnancy may be more advanced than anticipated. Patients may know the exact date of an unprotected sex episode, which may also guide gestational age assessment, or may have a recent negative pregnancy test.

Routine pre-abortion ultrasound scanning is unnecessary. However, if available, this should be used if there is clinically relevant uncertainty about the pregnancy duration, or if there is a suspected ectopic pregnancy (see Figure 2).

If the pregnancy duration cannot be assessed by reliable LMP and where ultrasound scanning is not available, an abdominal examination can help determine pregnancy duration when it is greater than 12 weeks. A bimanual examination can be performed if the practitioner is still unsure of pregnancy duration after an abdominal examination and the information gained would change clinical care. If there is a reasonable suspicion that the gestation is close to a limit where abortion may not be legally possible in that country, then confirmation of pregnancy duration should be conducted without delay.

Figure 2 Decision aid for pre-abortion ultrasound



Exclusion of ectopic pregnancy in high risk groups

Routine ultrasound examination is not necessary to screen for ectopic pregnancy. However, in all telemedicine consultations, a risk assessment should be included to identify those who may be at higher risk of an ectopic pregnancy. Patients at higher risk include those with a history of previous tubal surgery or pelvic inflammatory disease, use of intrauterine contraception at the time of conception, or previous ectopic pregnancy. Those with significant risk factors, or those with symptoms of possible ectopic pregnancy, such as bleeding and/or pelvic pain, should have an ultrasound scan.

Medical history

Medical history taking during abortion consultations should include a past medical history, drug history (including allergies), and past obstetric and gynaecological history. There should be particular focus on underlying conditions that might affect eligibility for a particular method of abortion, or influence whether the abortion can take place in the home setting, in a clinical facility, or in a hospital.

For more information, see the RCOG Best Practice Paper on abortion care: https://www.rcog.org.uk/guidance/browse-all-guidance/best-practice-papers/best-practice-in-abortion-care/

STI screening

At the telemedicine consultation, a risk assessment should also be conducted for STIs (e.g. HIV, chlamydia, gonorrhoea, syphilis). Patients should be offered STI testing at a clinic or by a self-test, but this should not delay the abortion procedure.

Blood tests

Pre-abortion assessment does not require routine blood tests. A determination of Rhesus blood status may be considered if the duration of pregnancy is more than 12 weeks and anti-D is available. Measurement of haemoglobin concentration or other blood tests are not required unless there are good clinical indications for doing so, such as for those with symptomatic anaemia.

Contraception discussion

The offer to discuss contraception should be sensitively initiated. Not everyone will want to discuss contraception at a pre-abortion telemedicine consultation. Health workers could raise the subject of contraception towards the end of the consultation when they have established a relationship of trust with the patient and plans for their abortion are in place. Health workers should avoid making assumptions about whether the patient will want or need contraception after their abortion.

Patients who do not want to discuss contraception should be informed about the timing of the resumption of fertility after an abortion. They should also be advised where they can access contraceptive services if they should want or need them in the future.

Patients who wish to discuss contraception should be asked about their preferences and needs. If appropriate, patients may be offered information about all their contraceptive options, without any pressure to choose a particular method. Advice can be given on the greater effectiveness and duration of long-acting reversible contraception (LARC) methods (implants and intrauterine devices [IUDs]) and of their safety, but no pressure should be put on patients to accept these methods.

All contraceptive methods can be started at the time of a surgical abortion. All contraceptive methods, except for IUDs, can be started at the same time as mifepristone and/or misoprostol is taken for medical abortion. An IUD can be inserted following confirmed expulsion of the pregnancy after a medical abortion.

There is some evidence to suggest that if the progestogen-only injection is given at the same time as mifepristone is taken for a medical abortion before 11 weeks of pregnancy, there is a small increase in the risk of continuing pregnancy. However, research also shows that most patients find having the injection at the same time as mifepristone to be acceptable. Healthcare providers are advised to tell patients about this possible risk and the need to confirm the success of the abortion, which can be done in the usual ways. It is important that patients are also offered the alternative of receiving the injection after misoprostol, which will not affect the efficacy of the medical abortion.

For those having medical abortion at home, and who wish and are able to self-administer the injection, a supply of the subcutaneous preparation of depot medroxyprogesterone acetate can be provided in the medication pack for home use.

Patients should be made aware that all hormonal contraceptive methods are immediately effective if started within 5 days of an abortion and all IUDs within 7 days of abortion (including the levonorgestrel-releasing IUD [LNG-IUD]). However, if any hormonal contraceptive method is started more than 5 days after an abortion, patients must avoid sexual intercourse or use condoms for 7 days. The exception to this is when starting the progestogen-only pill (POP), which only requires 2 days of condom use or abstention from sexual intercourse for contraceptive protection.

Since there may not be any in-person visits with telemedicine-delivered home medical abortion, this model of care can reduce the opportunities available to provide LARC. Providing LARC as soon as possible after an abortion can lead to higher uptake and a lower risk of a further unintended pregnancy than when provision is delayed. It is therefore important for abortion services to offer rapid access to a clinic where LARC can be provided. If the abortion service is unable to provide LARC or any other contraceptive method, the health worker should tell the patient where they can go for this, and offer a temporary 'bridging' method, such as the POP, which they can take until they can obtain their preferred method. A supply of POP may also be offered to patients as an alternative to combined hormonal contraception when blood pressure measurement is not possible and the prescriber has no access to a record of a normal blood pressure within the past 12 months.

For more information on contraception after abortion, see the RCOG Best Practice Paper on post-abortion contraception: https://www.rcog.org.uk/guidance/browse-all-guidance/best-practice-papers/best-practice-in-post-abortion-contraception

For patients wishing to try for another pregnancy soon after the abortion, the health worker should signpost them to reliable, quality information on pre-conception care.

Choice of abortion procedure and scheduling

Where possible, a choice of abortion procedure should be available. Options include medical (at home or in a facility) or surgical abortion. The chosen procedure should be scheduled as soon as possible after the telemedicine consultation, in line with the patient's wishes. If the patient plans to have a medical abortion at home, then arrangements should be made for the patient to receive the necessary medications as soon as possible.

If the patient is having a medical abortion (first or second trimester) in a clinical facility, then where possible they should be given the option of self-administering the first part of treatment (mifepristone) at home, if legally permissible in the country. If they choose this option, then mifepristone can be provided to take at the appropriate interval before the scheduled date on which they will then receive misoprostol at a facility and pass the pregnancy.

If the patient is having a surgical abortion, then where possible and legally permissible, they should be given the option of self-administering the medications at home for pre-treatment of the cervix (misoprostol and/or mifepristone) before the operation. This will minimise the number of visits and the travel required to a facility. Where possible, scheduling of care in a clinical facility should be flexible to accommodate the patient's life circumstances; for example, work or childcare arrangements.

Prescribing abortion medications

Prescription of medical abortion medications should be by a registered prescriber who has reviewed the patient's history to identify possible contraindications or cautions, any necessary modification to the standard drug regimen (such as additional doses of misoprostol for gestations over 10 weeks) and any interactions between their regular medications and hormonal contraceptive methods they wish to use.

Access to a prescriber during or shortly after remote consultations can minimise delays in dispensing medications. Prescribers may be on site or available remotely, depending on legal frameworks and locally agreed pathways. Quality-assured mifepristone and misoprostol medications must be available in the right dosage and with sufficient stocks.

Medication packs (see Box 1) can be sent directly to patients in the post (or other reliable delivery service), or collected from clinics or a pharmacy, depending on local service arrangement and legal requirements.

Box 1 Suggested contents of medication pack for medical abortion at home for gestations less than 12 weeks

- Mifepristone 200 milligrams to be taken orally and followed 24–72 hours later by loading dose of misoprostol (see below)
- Loading dose of misoprostol 800 micrograms to be administered sublingually, vaginally or buccally
- Two extra doses of misoprostol* 400 micrograms (total 800 micrograms)
- Oral antiemetic
- Oral analgesia, such as a nonsteroidal anti-inflammatory drug (NSAID) and/or weak opiate if not contraindicated
- Urine pregnancy test: low sensitivity (1000 IU human chorionic gonadoptrophin [hCG]) for use from 2 weeks, or high-sensitivity test (50 IU hCG or less) from 4 weeks after treatment
- Contraceptive supplies if wished: short-acting hormonal contraception, condoms, subcutaneous depot medroxyprogesterone acetate for self-injection

*If expulsion of the pregnancy has not occurred within 4 hours of the loading dose, then 400 micrograms misoprostol should be administered sublingually, vaginally or buccally. For pregnancy between 10 and 12 weeks of gestation, a further 400 micrograms of misoprostol may need to be taken 4 hours later if the pregnancy has still not been expelled.

Support for telemedicine-delivered medical abortion at home

People undergoing medical abortion at home delivered via telemedicine should have access to clear information on how to take the medications; what to expect from the procedure; how to manage pain, sickness or other common adverse-effects related to treatment; and how to determine if the abortion has been successful and that they are no longer pregnant.

This information should be available in a range of languages and formats, including written and audiovisual, so that the patient can refer to it before, during and after the procedure. Patients should also receive their health workers' contact details so they can receive further information and support if needed.

Patients can confirm complete abortion, based on physical signs and an appropriately timed urinary pregnancy test (if available).

Physical signs of a successfully terminated pregnancy include:

- Experiencing the expected amount and duration of bleeding
- Witnessing passage of pregnancy
- Resolution of typical pregnancy symptoms.

If available, the success of the abortion can also be confirmed with a:

- low-sensitivity urine pregnancy test with a detection limit of 1000 IU hCG from 2 weeks after treatment, or a
- high-sensitivity test with a detection limit of 50 IU hCG or less from 4 weeks after treatment.

Women using a progestogen-only method of contraception should be advised that although these methods can result in amenorrhoea, they should not attribute lack of bleeding after the medical abortion to the contraceptive. Therefore, it is still important to exclude a continuing pregnancy.

Aftercare

Specific signs and symptoms can indicate a complication requiring urgent medical help:

- Soaking through two or more maxi-size sanitary towels per hour, for 2 hours in a row
- Developing an unusual, unpleasant-smelling vaginal discharge
- Developing a fever or flu-like symptoms after 24 hours
- Developing worsening pain, which might indicate a rupturing ectopic pregnancy (for example, if lower abdominal pain is one-sided, under the ribs, or goes up to the shoulders).

Patients should be advised about these signs and symptoms, as well as where to go to get emergency help.

Health workers should also provide information on signs and symptoms that might indicate a continuing pregnancy or undiagnosed ectopic pregnancy, for which patients should seek medical attention. These signs and symptoms include:

- Having no bleeding, or only spotting or smearing of blood on sanitary towel or underwear in the 24 hours after misoprostol for medical abortion
- Still feeling pregnant 1 week after the abortion.

People can experience various emotions after an abortion. Health workers should provide information on how to access emotional support after an abortion in case this is needed.

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RCOG's global initiative to advocate for women's health

Royal College of
Obstetricians &
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Website: **www.rcog.org.uk/global-network**

Contact: **cfwgh@rcog.org.uk**