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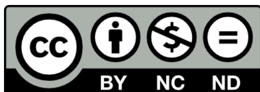

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Making the case for *supported* self-managed medical abortion as an option for the future.

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The use of misoprostol at home to induce abortion began in Brazil in the 1980s and spread rapidly to many parts of the globe. The combination of mifepristone plus misoprostol with safe and effective dosages and regimens rapidly became available through clinical provision and was included on the World Health Organization (WHO) complementary essential medicines list in 2005. In 2018, it was moved to the WHO core list of essential medicines and approved for self-managed abortion (SMA) at home up to 12 weeks' gestation, based on substantial evidence of efficacy, safety and acceptability in legally permitted settings (1).

Telemedicine counselling and long-distance provision of medical abortion pills for home use in legally restricted settings was begun in 2007 by Women on Web, a safe abortion hotline initiated by a feminist doctor. Access was greatly expanded when a second international hotline, Women Help Women, was launched in 2014. Telemedicine to counsel women and arrange SMA at home has been shown to be safe and acceptable in a systematic review of provision by both Women on Web and medical practitioners in the USA, Canada and Australia (2). A recent systematic scoping review on SMA found, in the studies covering the web-based hotlines, that telemedicine and SMA with abortion pills is safe and effective (3). The positive outcomes experienced by women, identified in both these reviews, were with *supported* self-managed abortion, that is, where women had access to information and support via telemedicine during the abortion process. This paper focuses on the importance of support to the acceptability of telemedicine and SMA. We examine these issues in the context of Great Britain (GB), where the self-administration of misoprostol – the second medication required for a medical abortion – had been permitted at home before COVID-19. The administration of the first medication – mifepristone – had taken place in clinic but, crucially, in almost all cases the abortion occurred at home.

Since the pandemic of COVID-19, six European countries, including GB began to permit telemedicine and SMA with abortion pills (4). The GB experience was evaluated in a large study comparing 29,984 SMAs with telemedicine (during the pandemic) to 22,158 in-clinic abortions (prior to the pandemic). This study not only found safety and efficacy with telemedicine to be as good as with in-person care, but also high levels of acceptability, improved access and earlier abortions. Moreover, a sub-sample of 2,453 women from the telemedicine SMA group provided post-abortion feedback, and 80% said they would choose SMA with telemedicine again (5).

Three GB-based client satisfaction studies also show high levels of acceptability. The first, among 1,243 Marie Stopes UK (MSUK) clients, found that 83% (n=1,035) said they would not have preferred to have seen a doctor or nurse in-person, and 66% (n=824) said they would choose telemedicine SMA again even if COVID-19 were not an issue. (6) The second, asked 1,333 British Pregnancy Advisory Service (BPAS) clients about their preferences if another abortion was needed in future: 77.8% said they would choose home use of mifepristone and misoprostol whilst 78.4% would choose a telephone consultation (7). A quantitative cohort study of 663 women in Scotland found that 95% (628) rated their care as very or somewhat acceptable; 123 (18.5%) had sought advice by telephone and 56 (8.4%) had attended a clinic for review (8).

This robust research evidence confirms that telemedicine with SMA is a highly acceptable, valued option. On the basis of this evidence, telemedicine counselling with SMA up to the current limit of 10 weeks should be approved permanently and increased to 12 weeks in line with WHO advice. We believe future research should focus on examining existing models of support and how improved support might further increase acceptability, but with an approach that does not restrict clinic-based options. This requires research that considers in more depth the experiences and preferences of women who might not choose telemedicine SMA.

In both the British studies (6,7), between 17% and 34% of the women said they would prefer not to have telemedicine SMA if they needed an abortion again. Whilst it is unclear whether this reflects uncertainty about the telemedicine aspect or the SMA aspect, or both, it is clear they would have preferred something different. The research evidence on what may have been difficult for the women, and why, is sparse. The MSUK study (6) found that clients who preferred face-to-face care mainly cited a desire for emotional and practical reassurance. This echoes an earlier study on web-based provision: women accessing services provided by healthcare staff reported high rates of satisfaction but those for whom medical guidance and reassurance were lacking during the abortion reported some distress (9).

There are similar clues about possible causes of distress in a recently published qualitative study of telemedicine SMA in Scotland (10) that does give indications as to which aspects of telemedicine SMA may require some attention. The majority experience (numerical indicators not given) was positive. Some women, however, reported 'panic' and 'fear' and difficulty being able to distinguish 'normal' from 'abnormal' effects when they had no one to ask: '"You don't have a nurse with you so when you're doing everything; you're like always questioning yourself 'am I doing this right?"'. Moreover, those who accessed the 24/7 phoneline for support, did so mainly for advice about pain and/or bleeding (9). The BPAS study also found a strong association between satisfactory pain control and overall satisfaction (7).

Thus, support and adequate pain relief may make all the difference in making the experience a positive one. The Moseson scoping review mentioned above reported that women experienced a range of conflicting emotions during the abortion, from gratitude to relief to fear. The authors argue that more information is needed to "understand how people manage these emotions and others before, during, and after abortion self-management". (3.p.19)

Based on the existing evidence, we would argue that *self-managed abortion should always be supported*, that is, there should be a 24/7 phone number women can call to get advice, emotional support and help if they want/need it. While the comfort and privacy of being at home have been identified as key to preferring SMA (6,9), they do not obviate the need for support.

Moreover, women may prefer not to be at home for a variety of reasons, including lack of privacy. It is therefore equally important to ensure that clinic-based service delivery should remain an alternative for those who would prefer it, as should surgical abortions. Some women have a negative experience with medical abortion and would not want to repeat it. Others would not choose a medical abortion in the first place but would prefer an aspiration abortion for a range of valid reasons, including certainty, speed and not wanting to have the experience at home (11). Thus, it is worth pointing out that the need for continued support is relevant with all abortions.

WHO says: "The decision about abortion management should be based on the individual's preference for treatment" (1). Client-centred, reproductive rights-based care (12) requires maintaining both the choice of abortion method and the choice of setting where the abortion takes place, as well as the availability of support during the process.

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