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Briefing Paper

SELF-MANAGED MEDICAL ABORTION VIA TELEMEDICINE

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FIGHTING FOR BODY RIGHTS SINCE 1933

SELF-MANAGED MEDICAL ABORTION VIA TELEMEDICINE

PURPOSE:
To provide a concise overview of self-managed medical abortions provided through telemedicine and how to create enabling environments for this practice.

INTENDED AUDIENCE:
Advocates and practitioners in the field of SRHR.

HOW WAS THIS BRIEFING PAPER MADE?
The present briefing paper is informed by scientific literature, international recommendations, and interviews with key informants (see acknowledgments).

INTRODUCTION

Abortion is a safe procedure1 and an essential component of sexual and reproductive health and rights (SRHR). Yet, barriers in access to safe and respectful abortion care remain a global challenge. Even in countries with liberal abortion laws, 13% of abortions are estimated to occur outside of formal healthcare,[2] and are deemed unsafe according to the World Health Organization (WHO) guidelines.[1] A wide range of factors might lead pregnant persons to obtain an unsafe abortion outside of formal health care, including fear of mistreatment by staff, long waiting lists, high costs, privacy concerns, and stigma.[3] Particularly during the COVID-19 pandemic, national lockdowns and severe mobility restrictions heightened the barriers in access to safe abortion.[4] In response to these challenges, self-managed abortion (SMA) via a number of pathways is a promising approach to facilitate access to care, increase privacy and confidentiality, and potentially bypass stigma.

What are self-managed abortions?

The self-management of abortion (SMA) broadly refers to the ability of pregnant persons to lead, in part or entirely, their abortion process. SMA is commonly practiced in both legally restrictive and liberal settings, with or without medical supervision, and using a range of different methods. This briefing paper focuses on self-managed medical abortions using misoprostol alone or combined with mifepristone, in countries with relatively liberal abortion laws. In such settings, SMA offers an additional pathway to abortion, and thus contributes to meet individuals' need for safe, respectful, and person-centered care.

The use of telemedicine for SMA

Among the different approaches to SMA, telemedicine offers one pathway that can support the self-management of the abortion process while enabling patients and providers to be separated by distance. The interaction may take place in real time (synchronously), using telephone or video link, or asynchronously using a store-and-forward method, when a query is submitted and an answer is provided later (e.g., by email, text or voice/audio message). This mode of service delivery can be used in combination with provider-led care to facilitate the self-management of one or several components of the abortion process, including:

1. Self-assessment of eligibility for medical abortion (determining pregnancy duration, ruling out contraindications);

2. Self-administration of medicines outside of a health-care facility and without the direct supervision of a trained health worker, and management of the abortion process;

3. Self-assessment of the success of the abortion.

Safe, effective, and acceptable: what research says about SMA via telemedicine

Up to 12 weeks of pregnancy, research indicates that telemedecine can support pregnant persons to safely and effectively manage their own medical abortions using misoprostol alone or in combination with mifepristone:

- Effectiveness and safety: compared to in-person abortion care, abortions provided through telemedicine are as effective and as safe in terms of both abortion completeness and complication rates[5]

- Acceptability to providers and abortion seekers: research consistently shows high satisfaction, feasibility, and acceptability among both health workers and abortion seekers[5–8]

• Cost-effectiveness: from a health systems perspective, evidence suggests that SMA via telemedicine incurs lower costs than in-person care.[9] For abortion-seekers, the costs entailed by SMA are context-dependent and have not yet been comprehensively studied.

WHO guidelines for abortion care

Provided access to accurate information, quality-assured medicines, support from trained health workers, and a health-care facility if the abortion seeker needs or desires it, SMA through telemedicine within the first 12 weeks of pregnancy is consistent with WHO's abortion care guidelines.[1] These guidelines include two recommendations relevant for the provision of SMA via telemedicine:

Self-management of medical abortion in whole or in part at gestational ages < 12 weeks

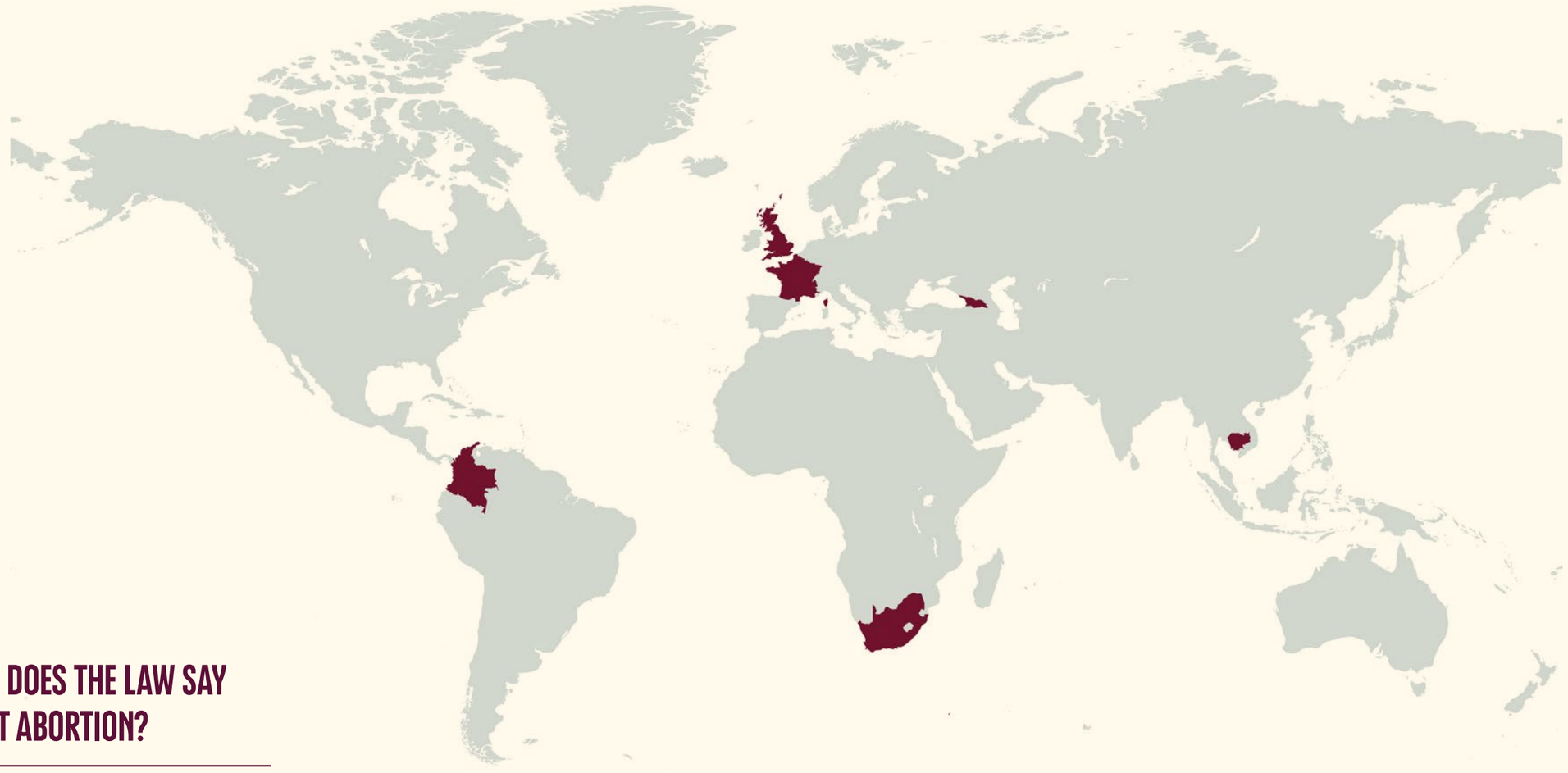
For medical abortion at < 12 weeks (using the combination of mifepristone plus misoprostol or using misoprostol alone): recommend the option of self-management of the medical abortion process in whole or any of the three component parts of the process: self-assessment of eligibility; self-administration of the abortion medicines ; self-assessment of the success of the abortion.

Telemedicine approaches to delivering medical abortion care

Recommend the option of telemedicine as an alternative to in-person interactions with the health worker to deliver medical abortion services in whole or in part. This applies to assessment of eligibility for medical abortion, counselling and instruction relating to the abortion process, providing instruction for and active facilitation of the administration of medicines, and follow-up post-abortion care.

While recommending self-management and telemedicine approaches to medical abortion, WHO also acknowledges that these should not be considered a "last resort" option or a substitute for a non-functioning health system.[1] Rather, WHO presents SMA via telemedicine as a potentially empowering and active extension of the health system.

CASE STUDIES: SIX COUNTRIES IN FOCUS



WHAT DOES THE LAW SAY ABOUT ABORTION?

Colombia

Legal on request until 24 weeks * (12 for medical abortion)

France

Legal on request until 14 weeks (9 for medical abortion)

*Gestational limits are measured from the first day of the last menstrual period.

UK (England, Scotland, Wales)

Legal on until 24 weeks (10 for medical abortion), provided that specific criteria are met[10]

Abortion remains susceptible to criminal offense[11]

South Africa

Legal on request until 12 weeks (10 weeks for at home medical abortion)

Georgia

Legal on request until 12 weeks (10 weeks for medical abortion)

Two appointments with a medical professional required (three in practice), including an ultrasound scan

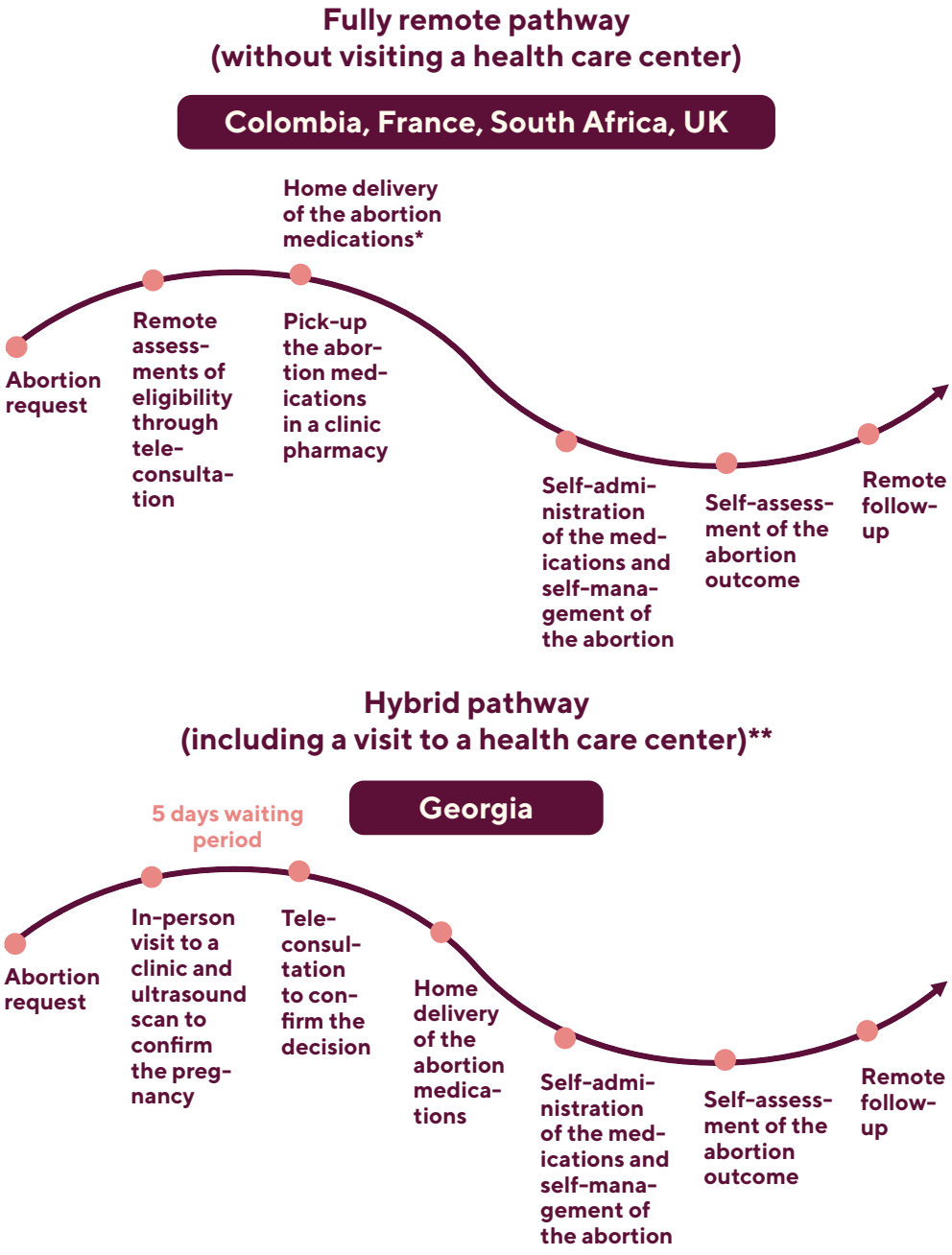
Mandatory five days waiting period between the 1st and 2nd appointments

Cambodia

Legal on request until 12 weeks (9 for medical abortion)

PATHWAYS TO SELF-MANAGED ABORTION VIA TELEMEDICINE

There are multiple ways in which a pregnant person can self-manage their abortion. Among the six case studies presented in this briefing paper, we broadly distinguish two pathways to SMA: fully remote pathways that don't require an in-person visit to a health care center, and hybrid pathways integrating in-person care and telemedicine. These pathways depend on the national context, and individual preferences on how to access abortion medications (e.g. via home delivery or in a clinic or pharmacy). In all cases, it is necessary to ensure access to a health facility should the abortion seeker need or desire it. To note, the telemedicine approaches outlined below facilitate the self-management of the administration of the medications and assess completion of the abortion, while the assessment of eligibility remains provider-led through an in-person or remote consultation.



* In France, the abortion medications are only available for pick-up in a local pharmacy.
** The approach trialed in Cambodia also falls into this category, but is not represented on the figure. The service has not reached many users (n=7), and the telemedicine pathway has yet to be defined for future scale-up.

Colombia

Context: Colombia has one of the world's most progressive abortion laws, framing abortion as a human right and allowing women to interrupt their pregnancy up to 24 weeks. However, numerous barriers to abortion care persist, leaving the most vulnerable groups behind. As inequities deepened during the COVID-19 pandemic, the Ministry of Health brought more flexibility to the provision of telemedicine services. This prompted Profamilia to launch "Mía" in 2020, a telemedicine service enabling a fully remote pathway to medical abortion up until 12 weeks of pregnancy.

Provider: Profamilia, a non-governmental organization and member of IPPF, promotes SRHR through research, advocacy, education, and provision of services via 54 sexual health clinics in Colombia.

Impact: After being pilot-tested in May 2020, Mía was made available nationally through all Profamilia clinics, extending access to safe abortion in numerous hard-to-reach municipalities.[12] Around 8% of all abortions provided by Profamilia currently employ telemedicine.*

Key learnings: Some challenges faced during the implementation of Mía included the need for training providers in the effective use of technology, uncertainties regarding insurance coverage of telemedicine services, and the lack of guidelines on how to provide abortion care via telemedicine.[7] Some providers expressed concerns about no longer being able to perform an ultrasound scan during the pre-abortion visit, and potentially missing contraindications. However, the Colombian government issued a regulation in January 2023 endorsing the WHO's position that ultrasound scans are not necessary to safe abortions, which reinforced the credibility of Mía. The service might not be suited to particular sub-groups which may need or prefer in-person care.

France

Context: Prior to the COVID-19 pandemic, individuals seeking a medical abortion in France were required to take the first medication, mifepristone, in the presence of a medical doctor or a midwife. During the first national lockdown in 2020, the French government temporarily lifted this requirement and allowed at-home medical abortion via teleconsultation until 9 weeks of pregnancy. This measure was made permanent in February 2022.

Providers: All office-based doctors, midwives, or health care centers with an agreement with a health care institution authorized to perform abortions.

Impact: An estimated 748 women obtained a medical abortion using the new telemedicine pathway in 2020, and 971 did so in 2021.[13]

Key learnings: The new telemedicine pathway has shown promise in reducing delays in accessing medical abortions, alleviating some providers' workload, and responding to abortion seekers' preferences for secrecy, privacy and comfort.[14] However, only 3% of office-based doctors and 4% of office-based midwives hold an agreement with a health care institution authorized to perform abortions, which might limit the reach of the service.[15] While they do not benefit from a conscience clause,** there is a risk that some pharmacists might refuse to provide abortion medications in practice. Abortion rights activists emphasize that face-to-face care remains preferable for certain abortion seekers, and that telemedicine should be framed as one option among many.[16]

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*According to the key informant interviewed for the present briefing paper.
**Conscience clause laws allow medical providers to refuse to provide services to which they have religious or moral objections.

UK (England, Scotland, Wales)

Context: In response to difficulties in accessing in-person abortion care during the COVID-19 pandemic, temporary measures were introduced in March 2020 in England, Scotland, and Wales to allow early medical abortion to be self-managed at home. While these measures were made permanent in 2022 in Wales and England, the Scottish Government is still due to decide on the matter.

Providers: Three main abortion providers in the UK offer a fully remote telemedicine pathway to obtain an abortion up to 10 weeks of pregnancy: the British Pregnancy Advisory Service (BPAS), MSI Reproductive Choices (MSUK) and the National Unplanned Pregnancy Advisory Service (NUPAS).

Impact: Taking both abortion medications at home has become one of the most common abortion procedure in England and Wales, accounting for 52% of all abortions in 2021.[17]

Key learnings: Compared to in-person care, users of the service report that being at home provides a more peaceful and dignified setting for an abortion.[18] The telemedicine pathway also appears time- and cost-efficient: since opening its telemedicine service, waiting times at MSUK were reduced by an average of four days.[6] While some providers appreciate the better flexibility and work-life balance they have gained by providing care via telemedicine, others express concerns about their ability to properly safeguard patients in the absence of face-to-face interactions.

South Africa

Context: Despite abortion being legal and available free of charge in public health facilities, around half of all abortions in South Africa are done by unlicensed providers. Access to formal services is hindered by abortion-related stigma, geographic disparity in the provision of abortion services, and a lack of skilled and willing providers. The temporary shut-down of all government SHRH clinics during the COVID-19 pandemic further exacerbated the country's unmet need for safe abortion. In response to these challenges, two non-profit organizations launched a telemedicine pathway for medical abortion under 10 weeks of pregnancy.

Providers: Marie Stopes South Africa (MSSA) started offering medical abortions via telemedicine in April 2020. In February 2023, Abortion Support South Africa (ASSA) launched a similar service in partnership with Women on Web. These two services differ in their cost (paying via MSSA vs free via ASSA), and in the mode of access to abortion medications (home delivery via MSSA vs pick-up in a pharmacy via ASSA).

Impact: Between 2020 and 2021, over 3,200 women accessed abortion care via MSSA's telemedicine service, with one in ten abortion seekers based in a region not previously served by the organization.[19] While it is too early to estimate the number of users of ASSA, the telemedicine pathway appears to reach women previously underserved by abortion services, especially in rural areas.

Key learnings: SMA through telemedicine appears highly acceptable among both abortion seekers and providers in South Africa.[8] From the perspective of users, telemedicine is convenient, increases privacy, and reduces the experience of stigma. However, some providers express concerns regarding the risk of inaccurately assessing gestational age in the absence of in-person care. Potential challenges to broaden the reach of telemedicine services include the need to provide additional information technology skills to providers, standardize guidelines for online consultations, and ensure reliable connectivity at clinics.[8]

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*According to the key informant interviewed for the present briefing paper.

Georgia

Context: Due to financial costs, geographical barriers, and persisting stigma, access to abortion remains challenging in Georgia, particularly for rural women. During the nation-wide lockdown in early 2020, public transportation was severely restricted, further limiting access to safe abortion. In response to these challenges, a simplified service delivery model leveraging telemedicine was piloted in April 2020 to reduce the number of in-person visits to a clinic from three to one.

Provider: Centre for Information and Counseling on Reproductive Health - Tanadgoma, a SRHR and mental health organisation based in Georgia's capital, Tbilisi.

Impact: Between April 2020 and March 2021, 119 women trialed the new approach.[20] Looking ahead, the organisation is working towards securing funding to expand the service in remote areas.

Key learnings: Abortion seekers were highly satisfied with the service.[20] By reducing travels to a clinic, the piloted approach is estimated to cost users one third of traditional in-person care.[20] Some of the challenges faced by Tanadgoma included difficulties setting an online payment system for the teleconsultations, delays in the postal delivery service, and providers' concerns that their revenue might be reduced due to the lower number of in-person visits. As a long term goal, incorporating telemedicine in the national guidelines on abortion would greatly facilitate the scale-up of the service.[20]

Cambodia

Context: In Cambodia, young, poor, and unmarried women living in remote areas are more likely to experience delays in accessing abortion care, fear stigma, and have difficulty in paying for and traveling to abortion services. In May 2022, the National Maternal and Child Health Center supported by the UNFPA issued technical guidelines on the provision of telemedicine for SRHR services. The use of telemedicine for abortion care is one of four components included in these guidelines. The recommended pathway includes a first visit to a clinic, self-administration of the abortion medications, and remote follow-up through teleconsultation.

Provider: Reproductive Health Association of Cambodia – RHAC, a non-governmental organization and member of IPPF, worked closely with the Ministry of Health in supporting its health centers to provide quality SRHR services.

Impact: The guidelines were piloted by RHAC in 16 selected health centers in two provinces, Battambang and Kampot. Between August 2022 and January 2023, across the 16 participating health centers, between 480-500 patients were provided with care via telemedicine. 1% of these cases were abortions, corresponding to 7 users.*

Key learnings: Key informants at RHAC observed that the issue of stigma also applies to telemedicine services, which might limit the scope of the service moving forward. In addition, due to a generational divide in the use of technology, older women might not be reached by this service. A technical challenge was raised in relation to the frequent practice of changing SIM cards, which might prevent effective follow-up of the abortion seekers. Some providers also express a concern that remote consultations will be charged less compared to in-person visits.

*According to the key informant interviewed for the present briefing paper.

Enabling access to self-management of medical abortion via telemedicine in the first trimester

Recommendations for civil society organizations and policy-makers

Self-management of abortion via telemedicine provides an additional person-centred, rights-based, and equitable abortion care pathway. When provided alongside clinic-based medical and surgical abortion care, this approach has potential to increase access to abortion care globally. To ensure this option is available and accessible, it is important that an **enabling environment**[1] is created for individuals to self-manage their abortions, including:

1. **A supportive law and policy framework that facilitates the self-management of abortion;**

2. **The availability and accessibility of accurate information about self-managing abortion;**

3. **A supportive health-care system that is prepared to support individuals who are self-managing their abortion at any stage of the process, including by enabling access to quality and affordable abortion medications.**

Both civil society organisations and policy-makers are essential to creating this enabling environment.

Components of an enabling environment	Recommendations for civil society organisations	Recommendations for policy-makers
Supportive laws and policies	Where the legal framework does not support (aspects of) SMA via telemedicine, advocate for legal and policy reform to facilitate this abortion care pathway.	Remove abortion from the penal code and end criminal penalties for women who self-manage their abortion process. Strengthen the legal and policy framework in support of SMA via telemedicine, given special considerations to disadvantaged groups. Ensure accurate and easily understood information about how to self-manage abortion (on all components of the process) including for low-literacy populations.
Accurate and accessible information	Develop public campaigns to increase health literacy regarding abortion care, bust stigma, and inform individuals about their right to manage their care, based on the available evidence and within the restrictions of their legal context.	Work in partnership with civil society organisations, healthcare professionals, and other relevant stakeholders to ensure that accurate information regarding SMA via telemedicine is available and disseminated widely.
Supportive health care systems, including quality and affordable abortion medications	Where mifepristone and/or misoprostol are not readilyavailable, advocate for improved access to theseessential medicines. Advocate for the update of clinical protocols and guidelines to include self-management via telemedicine as an additional abortion care pathway.	Register and include mifepristone and misoprostol on the national Essential Medicines Lists (in line with WHO EML) and work towards procurement and affordability of these medications. Provide and implement national guidelines on self-management approaches and the use of telemedicine for abortion care. Support and accelerate providers' training in the effective use of technologies Deliver telemedicine models to facilitate and support self-managed medical abortions.

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RFSU was founded in 1933 and is a pioneering Swedish organisation working in the field of sexual and reproductive health and rights (SRHR).

RFSU is a non-profit, non-governmental organisation without party-political, trade union or religious affiliation. Our aim is to spread a knowledge-based and open view of sexuality and relationships issues to overcome prejudices, bridge knowledge gaps andimprove sexual health and wellbeing. We run projects andprogrammes to promote access to sexual and reproductive health and rights – both in Sweden and internationally. Much of this workis done with partners and other organisations. RFSU has a rights perspective of sexuality based on everyone's freedom to be what they want to be, to choose to live as they want and enjoy what they want.
The International Planned Parenthood Federation (IPPF) was founded by RFSU and other actors, and RFSU remains IPPF's Swedish member association.
You can read more about RFSU's activities at www.rfsu.se

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