COVID-19 Forum Questions and Answers
April 29th, 2020

The April 29th members only Forum was focused on Medical Abortion and Early Pregnancy Loss and a number of questions that were posted by participants.
We have compiled the questions, and provided answers from experts within our field, with guidance that is applicable in the Canadian context. With limited published evidence, most answers represent consensus of expert opinion and were considered current at the time of the April 29th Forum.

Abortion Services
1. Has the COVID-19 pandemic affected access to abortion services or early pregnancy assessment clinics?
   - Some centres have been able to double or triple access to medical abortions (e.g., virtual visits) compared to those in person they were offering before and have noted a decrease in the number of surgical abortions, which was necessary because of PPE limits and provincial orders to limit in person visits wherever feasible. Surgical abortion nurse histories and counselling has also converted to phone only visits which have been well received by patients. There is still work to be done in those who do not have telephone access.
   - EPAC is also being provided in ERs in some regions, which was already planning to be done (for example in Manitoba), but COVID-19 pushed it to happen faster.
   - Feedback has been mixed in terms of the types of abortion services being offered– some patients are happy with, and qualify for, the no-test options and others are not. No-test abortion is being offered for almost all of the early gestation ages – some providers are comfortable extending beyond the early days, which depends on provider comfort in managing these patients for complications. Tests are being reserved for those patients whose condition generates enough questions to warrant testing.
2. Are the new SOGC statements on pregnancy termination expected to continue post COVID-19? For example, for patients who have a hard time getting ultrasound or who live out of town?

- This has been a fast learning curve, and everyone is looking closely at what they are offering and how they are offering it. One concern is the availability of blood where the patient is located – bleeding may be a couple of weeks later and it is important to have access to transfusion services, which may be an important consideration for very remote communities, and fly-in situations. Language barriers can also be a challenge in offering medical abortion and managing complications.

3. If you haven’t been providing medical abortion prior to COVID-19, is it reasonable to start offering it now? Is there support out there?

- Some have noticed more colleagues starting to offer medical abortion. It is important to mentor providers in the remote communities where the women are living. Having a local provider of medical abortion is an opportunity to have a positive impact from COVID-19. They realize they can do it themselves and it’s not that bad!
- COVID-19 has definitely has moved forward ability to offer service in some northern communities now that travel is difficult and has pushed policies forward.
- SOGC has supported the UBC-based CART Mifepristone Implementation study to create a “Community of Practice” for health care providers of medical abortion service. The Canadian Abortion Providers Support (CAPS) is available to licensed health care professionals at www.caps-cpca.ubc.ca and provides a range of guidelines, handouts, ‘ask an expert’ and ‘find a pharmacy’ and other resources to support medical abortion care.

4. Will Medical abortion have an impact on the previous stigma associated with pregnancy termination? Are we seeing a shift in the stigma at all?

- Overall, it has been refreshing to have seen the lack of stigma in the general Canadian population overall, including that portrayed by the media.
Now, more than ever, medical options and now virtual options for abortion services will encourage patients to seek the care that they need.

5. What happens if a molar pregnancy is not detected by not getting a pre-medical abortion ultrasound and mifepristone is given?
   • This really depends on the ability to do tests. If there was no test, the patient would likely present with bleeding at some point – she would call the 24 hr hotline, and if there is too much bleeding (2 pads over two consecutive hours), she would be told to go to the hospital.
   • If testing had been done, serum hCG would have been measured on the day of the abortion and another 7 days after. If initial or follow up levels were abnormal, follow up would be required– likely with ultrasound. Patients with a follow up urine testing would be found to have increased hCG at 4 or 5 weeks with serum test and this would warrant further follow up.
   • Partial molar pregnancy may not be evident, even based on the hCG values – a complete molar pregnancy would be more likely to be identified.

6. Mifepristone was not available in Alberta for the last 2 weeks; is that a local problem or more?
   • Availability varies across the country and shortages have also been reported in Toronto and Timmins...
   • If there is no availability, you will have to wait or use another alternative (i.e., scheduling for a surgical abortion, waiting for medication to be available). It would be important to connect with other pharmacies in your province or another clinic to see what their supplies are.
   • Some providers have used methotrexate and misoprostol as per the SOGC Medical Abortion guideline of April 2016. These can take a longer time to achieve complete abortion than mifepristone/misoprostol.
   • Using misoprostol alone is another option also discussed in the guideline, but it is far less effective and results in a high proportion of side effects - this should be used only when no other options are available.
7. *Is mifepristone covered in most places as that is a limitation locally in Alberta?*
   - It has been believed that all provinces have been paying for mifepristone since 2018, given that they pay for surgical abortion, although there are restrictions for non-provincial residents. Non-Insured Health Benefits covers for all their eligible patients.

**Contraception**

8. *What are you recommending for contraception post medical abortion?*
   - Despite the restrictions associated with the COVID-19 pandemic, all the same options are discussed and then choices are made based on options available, anticipating that those who need to have in-person procedures (i.e., IUC) will be able to come in soon.
   - Recommendations really depend on patient risk factors and what’s available in your area (i.e., sometimes pharmacists can administer injections).