Clinical Notes for the Victorian Rural Clinical Network for Unintended Pregnancy and Abortion meeting – Tuesday 24 March 2020

Focus: Providing abortion services in the time of covid19 pandemic. Working with women and pregnant people undertaking an abortion.

Facilitators: Dr Paddy Moore and Cath Hannon, The Women's

Acknowledgment that the pandemic represents an unprecedented situation and requires clinicians to respond based on the best available evidence while assessing safety and risks to the woman or pregnant person concerned, health professionals and the health care system.

Acknowledgment that abortion is essential health care & support RANZCOG recommendation that timely access to medical and surgical abortion is classified as category one.

Scenarios for discussion

In the context of the covid19 pandemic likely situations to have encountered or are likely to encounter:

1. person in quarantine or self isolation seeking a medical abortion (MA), how to access MA and associated investigations (ultrasound, pathology)
2. person partway through MA procedure & required to self isolate or quarantine due to illness or exposure to COVID-19
3. follow up of MA & options for contraception
4. are there any potential shortcuts? what are the minimum standards of care for MA
5. back up options in the case of nurse-led models of care and clinician unavailability to provide MA consent & script
6. how to respond in the context of a potential border closure

Scenario 1, quarantine & self isolating woman pregnant person seeking a MA:

- guided by the principle of making the solution as simple as possible in these complicated times
- acknowledge difficulty to fulfil request for MA at this time. Tend toward a conservative approach ie wait until quarantine or isolation period complete, decrease harm to the broader service system to have person wait until quarantine & isolation period complete. Provides greater protection for health system & workers involved in care, however acknowledge increased psychological distress for the person concerned.
- recommend course is to offer surgical abortion once isolation period is complete. However, the impact of this course of action will be psychological impact on the individual concerned and difficulty to access an abortion later in pregnancy. Inevitably women & pregnant people will need to travel to Melbourne/The Women's to access a surgical service. In addition, some people may be unable to access a service at all and will result in a continuing unintended/unwanted pregnancy.
- create new pathways of care: services are being creative & providing flexible methods of service delivery such as telehealth/videoconferencing for some or all of the

consultation, ie faxed script direct to pharmacy or clinic pick up for MA, preadmission assessment for surgical abortion, whole consultation online & follow up with low sensitivity urine test.

- guidelines for GP telehealth consultations have been relaxed (see tools)
- acknowledge increased risk of IPV & reproductive coercion at this time of isolation. Highlights the need to screen to safety to help protect the individual concerned. See tools.
- low sensitivity urine test to follow up completeness of MA procedure, used approx. 14days post miso, now on the market, an alternative to beta hCG. cost $18.50 per single unit, to order sales@medind.com.au. Sales rep Peter Thompson 0406722269.
- option to offer MA up to 10 weeks gestation, available on PBS to 9/40. Pt would pay cost difference approx. $350
- providers report difficulty accessing a timely ultrasound, on request form use "exclude ectopic" to prioritise a scan
- RANZCOG advises that a clinician may appropriately decide not to administer anti-D prior to 10 weeks, for medical management of abortion, particularly when an additional visit may increase exposure of women and staff. For surgical management of abortion prior to 10 weeks, checking rhesus status, and administration of anti-D, is discretionary, based on the individual woman's risk benefit profile and her preferences. See tools.

Scenario 2: person becomes unwell, develops a fever during the MA procedure

- consider fever associated with side effect of misoprostol
- use DHHS self assessment tool to support decision making (see tools)
- inevitably will confront these situations & will need to make clinical decisions based on presentation

Scenario 3: Follow up contraception

- script for OCP at time of MA consultation as a secondary option (LARC preferred course) just in case person is subsequently in quarantine or self isolation (to start OCP day following miso & once products of pregnancy are passed)
- option for Implanon on same day as MA(mife) in the context of a clinic visit, limitation in primary care having an imprest supply of Implanon to support decision

Scenario 4: are there options for shortcuts?

- overseas jurisdictions are finding difficulty accessing ultrasound & are investigating the minimum requirements in Australia
- standard of care is to confirm IUP, therefore ultrasound required
- increased risk of medico legal insurance cover re telehealth management in the absence of ultrasound
- need more flexible options in clinics that have the resources ie tertiary or regional services
- RCOG Covid19guidelines, MA offered without routine investigations ie no ultrasound & blood pathology, see tools. Note these are UK guidelines therefore laws & service system context different & not directly applicable to Australian context.

Scenario 5: Back up options for nurse-led models of care and clinician unavailability

- The Clinical Champion Project, The Women's have an established telehealth model of care option offered alongside S&RH nurses in rural services. Process is established, could be easily adapted to a scenario there is a nurse led model but no clinician for consent and script. For more information contact Catherine.Hannon@thewomens.org.au for more information.

Scenario 6: responding to border closure

- Very difficult to plan contingency, hopefully NSW-Vic border closure unlikely

1800 My Options update

- report a high degree of fear and uncertainty in the community
- access & availability of services - reports from women having difficulty accessing ultrasound services, not being able to access MAservices due to lack of financial resources having lost employment etc & reduced capacity to pay for services.
- the whole 1800 Myoptions service has gone remote, call back model. Phones not fully diverted, minor delay, however able to meet demand. Working with Telstra to have the phones fully operational.
- heightened need to consider safety for women, increase in reports of IPV & reproductive coercion
- MS may be able to provide options such as payment plan etc

Next meeting 7 April 6pm, via zoom.

Agenda: Clinical case study, women with persistent bleeding following medical abortion