"Liberating women - removing barriers and increasing access to safe abortion care"

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Abbreviations
PS: Plenary session
CS: Concurrent session
LS: Lunch session
FC: Free communication
P: Poster presentation

Plenary sessions

PS1.1

The Global Abortion Policies Database – a policy tool designed to increase the transparency of global abortion laws and policies and state accountability for the protection of women's and girls' health and human rights

Antonella Lavelanet, World Health Organization, Switzerland

WHO strives for a world where all women's and men's rights to enjoy sexual and reproductive health are promoted and protected, and all women and men, including adolescents and those who are underserved or marginalized, have access to sexual and reproductive health information and services. Access expressed through laws, policies, and guidelines is a key component of the enabling environment for safe abortion. However, abortion laws and policies can be punitive or protective; specific or non-specific; confusing and even contradictory at times, all of which may exacerbate a chilling effect on those who seek, provide or advocate for access to services.
Launched in June 2017, the Global Abortion Policies Database (GAPD) contains abortion laws, policies, standards and guidelines for UN and WHO Member States designed to strengthen global efforts to eliminate unsafe abortion by facilitating comparative analyses of countries' abortion laws and policies. The abortion laws, policies, and guidelines within the GAPD are juxtaposed to information and recommendations from WHO safe abortion guidance, national sexual and reproductive health indicators, and UN human rights bodies' guidance to countries on abortion.
This presentation provides a brief overview of the GAPD, an analysis of selected countries, and demonstrates the vagueness and complexities that exist in laws and policies.

PS1.2

Do we need abortion laws? Legal perspective

Joanna Erdman, Dalhousie University, Canada

This presentation interrogates the idea of 'need' in abortion law and explores how we assess claims of necessity under international human rights law. Using examples from the Global Abortion Policies Database, the presentation highlights the arbitrariness, overbreadth and dysfunction that characterize much abortion law worldwide, including many liberal regimes. These laws do not achieve the ends they purport to serve, and often undermine ends of public health, safety, and morality. The presentation focuses on the harms of unnecessary abortion law including: public health impacts of dysfunctional laws, access inequalities of overbroad laws and abuses of arbitrary laws. Particular attention is given to the harms by which abortion law becomes normative or even prescriptive of our lives. How law comes to shape the very ways we understand, experience and practice abortion. For example, how law and its institutional controls were traditionally used to define abortion safety, and the impact today on how we regulate self-managed abortion. We have given law much imaginative power over our field. For too long, we built norms of abortion practice in the image of the law, rather than having law serve aims of health and human rights. Today still, we carry over many falsehoods of abortion law into research, practice and policy, such as when health regulations carry on the gatekeeping and punitive work of criminal law. The presentation thus concludes with the idea of 'freedom from law,' an open and imaginative outlook that steers us away from the classic terms, binaries, and frames of abortion law that have patterned our field (e.g. risk and harm, time boundaries, set indications, protections and limits). The presentation extends an invitation to think ourselves away from the routines of abortion law and to ask: What do we need or want from law?

PS2.1

Safe medical abortion at very early gestation

Alisa Goldberg, Harvard Medical School, Brigham and Women's Hospital, United States

Women are seeking abortion at increasingly earlier gestations, with 41% of first trimester patients in the U.S. receiving an abortion at ≤6 weeks gestation. The efficacy of medical abortion at ≤6 weeks gestation is not significantly different than at 6-7 weeks, however, seeking abortion very early in gestation increases the likelihood that providers will have difficulty visualizing the pregnancy on ultrasound, the current standard of care in many clinics.

The most serious risk of treating women with an undesired pregnancy with mifepristone and misoprostol without first confirming a diagnosis of intrauterine pregnancy is a missed diagnosis of ectopic pregnancy. Studies suggest an incidence of ectopic pregnancy of 0.2-0.3% among women presenting for medical abortion. Data support the practice of providing mifepristone and misoprostol medical abortion in the setting of undesired pregnancy of unknown location (PUL) using serial serum hcg testing to simultaneously exclude ectopic pregnancy and determine the efficacy of the medical abortion. Guidelines that enable provision of medical abortion in the setting of PUL, when the patient is asymptomatic, low-risk for ectopic and when combined with close follow up to exclude ectopic pregnancy exist to support this service development.

This presentation will review the evidence for providing medical abortion at ≤6 weeks gestation including in the setting of PUL.

PS2.2

Simplifying early surgical abortion

Patricia Lohr, British Pregnancy Advisory Service, United Kingdom

Medical and surgical methods of abortion are highly effective, safe, and acceptable to women. Women value being offered a choice of methods and receiving a preferred method is a strong predictor of satisfaction with care. For women who do not have a strong preference for a particular method, clinical trial evidence suggests that randomisation to a surgical abortion results in higher satisfaction rates than randomisation to a medical abortion. While providers may wish to optimise women's abortion experience by offering a choice of methods, this can be challenging with the increasing shift toward medical methods and the very early gestational ages at which women now present for abortion care. Surgical abortion under general anaesthesia may be cost-prohibitive and the predominance of medical abortion in some settings can reduce opportunities for obtaining surgical skills. Providers may be uncertain of whether or how to offer surgical abortion in the earliest weeks of pregnancy.
This talk will address the evidence supporting the offer of a choice of abortion methods and will discuss less resource intensive models of outpatient surgical abortion care as well as a protocol for providing surgical abortion before a gestational sac is visible on ultrasound.

PS2.3

Immediate contraception after first trimester abortion

Oskari Heikinheimo, University of Helsinki and Helsinki University Hospital, Finland

When planning post-abortal contraception it is important to note that women seeking trimester termination of pregnancy (TOP) have demonstrated their high fertility and are at risk of subsequent induced abortion. The importance of the efficacy of the post-abortal contraceptive method has been increasingly recognized during the last decade. A safe and highly effective method with minimal dependency on the user compliance, *i.e.* long-acting reversible method of contraception (LARC) is clearly of value. When compared to use of LARCs and especially intrauterine contraception (IUD), use of oral contraceptives or postponing initiation of contraception is associated with a significantly increased risk of subsequent TOP.
Placement of an IUD immediately at the time of first trimester surgical abortion is the standard of care and it is also recommended in international guidelines. In comparison to delayed insertion, the expulsion rate is somewhat higher (5 *vs.* 3 %). following immediate insertion. However, the number of IUD users during the follow-up is increased when compared to delayed insertion (92 *vs.* 77 %).
Increasing use of the medical TOP and home administration of misoprostol pose challenges to provision of post-abortal contraception. However, progestin implants can be safely inserted on the day of mifepristone administration. A recent RCT comparing fast-track insertion (≤3 days *vs.* 2-4 weeks after misoprostol administration) of the levonorgestrel-releasing intrauterine system (LNG-IUS) after first trimester TOP has shown that also rapid initiation of intrauterine contraception is feasible. Fast-track insertion is associated an increased risk of partial expulsion (12.5 *vs.* 2.3%).

However, fast tract insertion was safe with similar rate of adverse events, and identical bleeding profile as that associated with later insertion. At one year of follow-up the user rate was higher and number of new pregnancies lower if the LNG-IUS had been inserted immediately.
Thus, an effective, quickly-started long acting contraception should be the goal of treatment regardless of the method of TOP as long as a new pregnancy is not planned. To reach this contraceptive initiation should be an integral part of comprehensive patient friendly abortion care with low threshold and easy access. This will also reduce the need of additional visits, subsequent TOP, and allows initiation of an effective contraception, with all its added health benefits.

PS3.1

The Contraceptive Paradox

Christian Fiala, Gynmed Clinic, Austria; Joyce Arthur, Abortion Rights Coalition of Canada, Canada

Today, a dream has come true: for the first time in human history we have the ability to effectively separate fertility from sexuality due to an unprecedented number of highly effective contraceptive methods and the availability of safe abortion. This has allowed us to effectively limit natural fertility to the individually desired number of children.
It began with the introduction of the birth control pill in 1960, which was hailed at the time as one of the biggest revolutions in human history. The development of effective and safe IUDs quickly followed. The ability to have sex without getting pregnant was very much welcomed by women and their partners and hormonal contraception became the standard within a few years. As a consequence, abortion rates began to decline.
While abortion continued to decline in some countries with good contraceptive access, rates have remained stable or even increased in other countries with reliable abortion statistics, such as the UK, France and Sweden. This is even more surprising as significant further improvements in hormonal contraception have been made since the introduction of the pill, namely with long acting reversible contraceptives (LARC).
This contraceptive paradox and the underlying reasons need to be analyzed if we want to use currently available contraceptive methods up to their full potential and effectively reduce unwanted pregnancies.

PS3.2

Fertility control: what do women want?

Hang Wun Raymond Li, The University of Hong Kong Pokfulam, Hong Kong SAR

There is wide variability in contraceptive choices and preferences among different populations. None of the commonly available contraceptive methods is perfect, and each method has its own merits and limitations. Important factors that commonly determine women's contraceptive choice include effectiveness, safety and side effects, affordability and accessibility, user friendliness as well as non-contraceptive benefits. The relative importance of these attributes varies between different users and is influenced by one's own fertility planning as well as her physical, social and cultural circumstances. While effectiveness is emphasised by most providers, the acceptance and satisfaction is greatly determined by the perceived or actual safety and side effect profile. Menstrual bleeding changes may positively or negatively affect method satisfaction and continuation.

Concerns about weight gain, effects on sex life and other side effects are also important reasons for method discontinuation, and these may be exaggerated by myths and misconceptions. Affordability and accessibility do vary with specific populations. Improved user-friendliness can be conferred by promoting the use of long-acting reversible contraceptives which are generally easy to use, more "forgettable" and less user-dependent. Non-contraceptive benefits such as improvement of menstruation-related symptoms and acne by hormonal methods and prevention of sexually transmitted infections by condoms are additional merits to some users. Healthcare providers generally have great influence on the contraceptive choice of most women. The tiered-effectiveness approach combined with shared decision making can be a useful way of contraceptive counselling. Within the effectiveness framework, the most effective methods are discussed first, while addressing the user's own concerns, preferences and reproductive goals. This aims at achieving the optimal balance between effectiveness and other attributes based on the user's personal circumstances.

PS3.3

The contraceptive continuum

Kristina Gemzell-Danielsson, Karolinska Institute, Sweden

Today many women are reluctant to use any of the existing contraceptive methods due to side effects or fear of experiencing such effects. Unsafe abortion is a major contributor to maternal mortality. Therefore effective methods for contraception and safe and acceptable methods for termination of unwanted pregnancies are prerequisites for reproductive health, for gender equality and for the empowerment of women. New methods for contraception are also needed including improved methods for emergency contraception and new mechanisms of action as well as mode of delivery. Additional health benefits of contraceptive methods such as protection against various cancers, and a wide range of other benefits need to be better recognized. Based on their mechanisms of action Progesterone receptor modulators (PRMs) can be used for emergency contraception as well as regular contraception by various modes of delivery. Progesterone receptor modulators have been shown to be effective when used on demand post coital, as daily pills, once-weekly or once-a-month and is a well establish method for medical first and second trimester abortion. The use of progesterone receptor modulators for contraception and positive health benefits such as the possible protection against breast cancer as well as prevention of uterine leiomyomas and endometriosis deserves to be further explored. Progesterone receptor modulators have also been studied for "late emergency contraception" and for menstrual induction. Very early medical abortion (VEMA) before an intrauterine pregnancy can be visualized by ultrasound has been shown to be acceptable, safe and effective. Medical abortion is also highly effective later in the first trimester and can be self administered by women. Thus PRMs such as mifepristone if offered in a suitable dosage provides a model for a woman centred contraceptive continuum with added health benefits and increased autonomy for women.

PS4.1

Women and providers: stigmatised and stigmatisation

Lisa McDaid, University of Glasgow, United Kingdom

Abortion remains a contentious and stigmatised medical procedure, despite being a commonly performed gynaecological procedure.
It is often framed as a moral, religious or legal issue rather than a medical one and is reinforced at structural, policy, community, and individual levels. Abortion stigma is a multifaceted phenomenon, impacting on the experiences of women who undergo abortion and the health care professionals involved in abortion care. Public discourses focussed on particular types of abortion that are viewed as problematic – 'repeat, 'late' – are further stigmatising and potentially discriminating. Even the language itself is inherently judgemental. This presentation will review contemporary evidence of the experience of abortion stigma among women and providers, the implications of this for health and wellbeing and inequalities, and how abortion stigma can be countered and challenged.

PS4.2

Overcoming restrictions to access

Rebecca Gomperts, Women on web/women on waves, Netherlands

All restrictions to access abortion services, legal logistic financial, creates social inequality. Women with access to financial means and information will always be able to access safe abortion services and women without the financial resources are most affected by these obstacles. abortion laws. Women on Waves and Women on Web use new technology (drones, robots, internet, apps) and research, to break the taboo around abortions and change policies and laws and in the same time make sure women have access to contraceptives and safe medical abortions. This presentation will highlight some of the work, achievements and challenges in the past years.

PS4.3

How can we sustain comprehensive abortion services

Ann Furedi, British Pregnancy Advisory Service, United Kingdom

The final session in Plenary 4 looks at how we can build a resilient cadre of abortion providers that is proud to offer women the means to control their fertility and will respond to some of the problems raised throughout the conference.

Concurrent sessions

CS 2.1

Pain & first trimester surgical abortion

Alison Edelman, OHSU & Ipas Consultant, United States

The quest for the optimal regimen for pain control for first trimester surgical abortion is ongoing. The desired characteristics of an optimal regimen include safety, efficacy, relatively inexpensive cost, and easy to administer. Although paracervical blocks and nonsteroidal anti-inflammatory medication in combination with non-pharmacologic methods (heating pad, support person) fulfil these criteria - many women still experience significant levels of pain during their procedure. To complicate matters, many clinicians have strong feelings that their pain regimen approach is best but as clinicians have been shown to underestimate the amount of pain women are experiencing, rigorous testing of these regimens are needed. Finally, a woman's perception of pain is complex with both physical and psychosocial elements that have been associated with higher levels of pain including parity, age, and anxiety levels. The current literature will be discussed as well as a brief review of the pathophysiology of abortion-related pain, patient characteristics associated with increased levels of pain, a practical approach to care and research gaps.

CS2.3

Anti D and early abortion

Ellen Wiebe, University of British Columbia, Canada; Mackenzie Campbell, UBC, Canada; Carolien Zwiers, Leiden University Medical Center, Netherlands; Abigail Aiken, University of Texas at Austin, United States

National guidelines on Rhesus (Rh) testing and treatment with Rh (anti-D) immune globulin (RhIg) for spontaneous and induced abortion vary between countries. Rh alloimmunization (also called isoimmunization) may harm subsequent pregnancies, but there is a lack of evidence that this occurs in early gestations. We should stop testing Rh status and administering RhIg to women having an induced or spontaneous abortion at early gestations if this is shown to be unnecessary, because this interferes with access to abortion and incurs extra cost. In the Netherlands, the policy is to not treat Rh-negative women having medication-induced or spontaneous abortions under 10 weeks' gestation and surgical abortions under 7 weeks', while in Canada all Rh- negative women are treated. We compared the clinically significant Rh alloimmunization rates in Canada and the Netherlands to determine whether the Dutch policy could be safely adopted by other countries. National guidelines from Canada and the Netherlands were obtained for the period of 2006 to 2015, and public databases were consulted to obtain national rates of abortions, births, Rh negativity, and the number of women with clinically significant perinatal antibodies. For Canada, the total fertility rate was 1.56, the abortion rate was 1.9%, and the Rh negativity rate was 13.0%. For the Netherlands, the total fertility rate was 1.66, the abortion rate was 1.2%, and the Rh negativity rate was 14.5%. In Canada, out of 573,206 samples tested in pregnant women, 0.0043% had clinically significant perinatal antibodies. In the Netherlands, out of 1,816,457 samples tested, 0.0040% had clinically significant perinatal antibodies.

This provides evidence that the Dutch policy of not treating Rh-negative women having medication-induced or spontaneous abortions under 10 weeks' gestation and surgical abortions under 7 weeks' can be safely adopted by other countries.

CS3.1

Mife by Mail: Findings from a telemedicine abortion service in the U.S.

Erica Chong, Gynuity Health Projects, United States; Elizabeth Raymond, Gynuity Health Projects, United States; Bliss Kaneshiro, University of Hawaii John A. Burns School of Medicine, United States; Maureen Baldwin; Oregon Health & Science University, United States; Leah Coplon, Maine Family Planning, United States; Paula Bednarek, Planned Parenthood Columbia Willamette, United States; Esther Priegue, Choices Women's Medical Center, United States; Beverly Winikoff, Gynuity Health Projects, United States

Objectives: In the United States, many women struggle to obtain an abortion due to ever-increasing barriers to access. The TelAbortion Project provides medical abortion directly to women in their homes using telemedicine and mail, enabling them to receive services without going to a clinic. We will report on interim findings from the first two years of the project.
Methods: TelAbortion is available in Hawaii, New York, Maine, Oregon, and Washington. Interested women contact implementing sites and interact with clinicians by videoconference. After obtaining screening tests at radiology and lab facilities close to them, eligible women are mailed packages containing mifepristone and misoprostol. Women take the medications at home, obtain follow-up tests and have another consultation with the clinician.
Results: Through June 2018, 200 women had received medication through the project. Of the 70% who were followed to completion, 5% had a surgical completion. The vast majority of packages were sent within two weeks after the initial study contact, and all women reported taking the mifepristone at gestational ages of 72 days LMP or less. No related serious adverse events were reported. All women reported being very satisfied or satisfied, and the most commonly reported best features of the service were the convenience and privacy.
Conclusions: Direct-to-patient telemedicine abortion is feasible and can potentially increase access to abortion care in a safe and acceptable manner. Although telemedicine bans and other restrictions are on the rise, TelAbortion could plausibly be legally implemented in about half of the 50 states, where about 56% of the female reproductive-age population reside.

CS4.2

Conscientious objection versus conscientious commitment

Anne Verougstraete, VUB Dilemma (Vrije Universiteit Brussel) - Hôpital Erasme ULB (Université Libre de Bruxelles) - Fédération Laïque de Centres de Planning Familial (FLCPF), Belgium

How will we be able to secure the right for abortion? Around the world, in a lot of countries where abortion is legal, women have great difficulties to have access to abortion. A few countries have regulations that state CO is not permitted for health care providers working in the field of reproductive health (Sweden, Finland, Iceland).
Is this an actual solution for other countries? In most countries, individual CO is written in the abortion law and in medical law, and in Belgium, abortion providers agree to this.

Which woman wants to be treated by a team that has a negative feelings towards abortion? Anti-choice health care workers obliged to work in the field of abortion could make it a traumatic experience!
In countries where CO is permitted, our actual fight should focus on the following:
The state should ensure that abortion services are available in each region (in hospitals or in outpatient facilities) and make sure women know where to go. Public hospitals should offer an abortion service if they want to keep their state funding. Public hospitals should not have the "right" of conscience. Objector status of doctors should be public and quick referral to an abortion service mandatory. Providers, who work in abortion services, should choose to do so (conscientious commitment) so that women are treated with respect and empathy. Doctors performing abortions should not be discriminated and should be dismissed from other tasks who need to be taken over by conscientious objectors. Women's rights movements should encourage feminists to become doctors and young doctors to perform abortion and be proud to do so. We need to do a charm offensive to show that working in abortion care permits rich human encounters with women grateful to be able to decide about their future life.

CS5.1

How women's voices changed minds in Ireland: The use of evidence to inform policy debate and public discourse on the Eighth Amendment

Abigail Aiken, University of Texas at Austin, United States; Kathleen Broussard, University of Texas at Austin, United States; Dana Johnson, University of Texas at Austin, United States; Elisa Padron, University of Texas at Austin, United States

The Irish abortion referendum represented an historic moment for reproductive rights in Ireland. Strikingly, the overwhelming "Yes" vote from Irish voters was echoed and supported by a broad spectrum of Irish politicians. This presentation will describe the critical role played by scientific evidence in shaping the policy conversation and influencing the opinions of politicians. We will discuss both quantitative and qualitative findings about how women in Ireland access abortion and their experiences both traveling abroad to clinics and self-managing using online telemedicine. Looking ahead, we will also examine elements of the new legislation Irish politicians are drafting to grant access to abortion up to 12 weeks gestation. Finally, since the political spotlight has now turned to Northern Ireland, where abortion laws remain among the strictest in the world, we will preview new research examining women in Northern Ireland's decision-making and experiences around abortion and discuss strategies for how this research might help support change.

CS5.2

Abortion law and policy in Northern Ireland: Its impact on access and future direction

Fiona Bloomer, Ulster University, United Kingdom; Claire Pierson, University of Liverpool, United Kingdom; Kathryn McNeilly, Queen's University Belfast, United Kingdom

Objectives**:** This paper considers recent developments in abortion law and policy in Northern Ireland and analyses their impact on access and future direction. Specifically, the paper considers: the investigation carried out by Committee on the Elimination of All Forms of Discrimination against Women (CEDAW); the implementation of the Centralised Booking System for those travelling to England; the implications of the Irish Referendum; political debates in the UK parliament and the recent Supreme Court Judgement.

Methods**:** the paper reviews research studies, political debates, policy documents, legal cases and considers the views of stakeholders (senior civil servants, health professional bodies, politicians, activists, trade unionists and academics).
Results**:** The restrictive legal context in Northern Ireland has resulted in only 16 abortions carried out by the NHS in the last reported year.In contrast 919 abortions were carried out in England to those with Northern Ireland addresses. Others self-abort at home, risking criminality in doing so. There is also evidence that abortion is a workplace issue – that women are unable to get sick leave, returning to work too soon and are uncertain who they can access support from.The CEDAW inquiry established that restricted access resulted in grave and systematic violation of human rights, including the chilling effect on clinicians of unclear law and policy, no referral pathway for post abortion care for those that travelled and no pathways for return of foetal remains.
Conclusions**:** the culmination of the CEDAW investigation and court judgements have identified human rights violations as a result of highly restricted access to abortion. This can only be overcome by decisive legislative action to address inadequacies, until then, for many needing an abortion, travelling to England or self-aborting at home, will remain a harsh reality.

CS5.3

The journey to bodily autonomy: How policy change has affected the experiences of abortion seekers from Ireland and Northern Ireland

Mara Clarke, Abortion Support Network, United Kingdom

Objectives: This presentation is an intimate and sometimes stark look at the groups most negatively impacted by the abortion law and policy in Ireland and Northern Ireland using real life examples of those still struggling to access legal abortion and the hardships they are facing.
Methods**:** The presentation is based on the experiences of clients who have contacted Abortion Support Network (ASN). As ASN's primary function is to provide financial assistance, the case studies will be of those who are marginalised, at risk, or otherwise without the financial means and support networks required to access abortion services without assistance.
Results**:** While those based in Northern Ireland are able to access free abortions if they travel to England, not all people are able to travel. In addition, ASN continues to be contacted by women who have no idea about the scheme allowing free abortions in England, which is obviously due to a lack of knowledge of the availability. Meanwhile, while the Republic of Ireland has repealed the 8th amendment, there has as of yet been no legislative change, and anyone who wants an abortion is still forced to take safe but illegal abortion pills or travel to another jurisdiction.
Conclusions**:** as an abortion fund ASN won't be drawing any conclusions until our phone stops ringing so often due to in country provision. For now, the only conclusion is the one we already know – that the criminalisation of abortion has always and will always most adversely impact the poor.

CS6.2

New experience in France of surgical TOP in primary care centers

Sophie Eyraud, REVHO, France

The health system modernization law in 2016 allows the practice of instrumental TOP without general anesthesia in primary care centers subject to partnership agreement with a hospital. The aim is to diversify the care offer and facilitate abortion access for women : proximity, rapidity, and real ability for women to choose the method. The Regional Heath Agency (Ile de France) has commissioned REVHO to assess the feasibility and to assist primary care centers in this practice. We have developed tools and training for medical practitioners and for the staff. Five pilot primary care centers were interested and eligible. Two years have been necessary for implementing the law providing for reimbursement of such practice by French social security (February 2018) and administrative constraints have delayed the beginning of this new practice outside the hospital. Last June, the first three surgical abortions were performed in Aubervilliers with great success and women's satisfaction. As for any new practice, it will take several years before a generalized implementation with possible extension to other structures and other professionals

CS6.3

Post-partum immediate insertion IUD

Solene Vigoureux, Maternité de Bicêtre, Hopital Bicêtre, France; Marie-Emmanuelle Neveu, Maternité de Bicêtre, Hopital Bicêtre, France; Sophie Gaudu, Maternité de Bicêtre, Hopital Bicêtre, France

The proposal of postpartum contraception is one of the recommended practices in the management of patients with childbirth (CNGOF recommendations post-partum 2015). Contraception should be chosen by the patient after a detailed explanation of the different contraceptive methods that can be considered based on her antecedents. Currently in France, contraception mainly proposed in the postpartum is the use of a micro progestin pill. Internationally, there are many countries offering post-delivery IUDs to women who wish to perform well on efficacy, tolerance and compliance. Patients are very often satisfied with being able to return home without having to worry about contraception. This technique is not yet part of practices in France. Firstly, we propose to evaluate the practices in France and the knowledge of the midwives and gynecologist-obstetricians and then we will present some result in a tertiary maternity unit.

CS7.1

MARE guidelines for reporting on medical abortion

Mary Fjerstad, Society of Family Planning and National Abortion Federation, District of Columbia, United States

Outcomes of various medical abortion research have been difficult to compare. Outcomes such as "effective", "successful", "complete" are defined differently in various studies or sometimes not defined. "Adverse events" similarly may not be reported or reported without clear definition.

The goal of Medical Abortion Reporting of Efficacy (MARE) guidelines is to standardize early medical abortion efficacy reporting to facilitate comparison of outcomes between studies and to enhance data synthesis from different studies. This brief presentation will discuss the MARE guidelines for research methods.
Eligibility: the eligibility criteria for participants should be clearly stated, including the range of gestational age, the methods used to determine gestational age, and the conditions for ineligibility.
Interventions: the study should state the medications used, including dose(s) and route(s) of administration. The planned time interval (in hours) between medications should be stated.
Outcomes: researchers should define primary and secondary outcome measures, including how and when they were assessed.

- Define successful medical abortion: MARE guidelines propose that "successful" medical abortion should be defined as successful expulsion of the intrauterine pregnancy without need for surgical intervention.
- There are several categories of medical abortion failure:
    - Ongoing pregnancy. Continuing pregnancy should be defined as a viable pregnancy following treatment (differentiated from a retained gestational sac)
    - Incomplete abortion

Heavy or problematic bleeding
Assessment: Describe follow-up assessment used to determine outcome, for example, combination of ultrasound and physical exam, any pregnancy tests, symptoms checklist, etc. State the length of time planned to follow participants to determine outcomes. Reporting outcomes in a standardized manner will enhance data synthesis to produce evidence-based guidelines.

CS7.2

A path to over-the-counter medical abortion

Nathalie Kapp, Ipas, United States

Increasingly, women are obtaining abortifacient medicines through pharmacies, drug sellers, and online or telemedicine services – particularly where abortion services are restricted or access is difficult. Many of these women are using medical abortion drugs safely on their own, although data on their clinical outcomes are limited. Many clinicians consider the self-use of medical abortion to be dangerous; however, from a strictly medical perspective, mifepristone and misoprostol meet many of the FDA criteria for being available over- the-counter (OTC): an acceptable toxicity profile, unlikely to be addictive, and a low abuse potential.
To demonstrate that medical abortion is appropriate for OTC distribution, a series of investigations would be required by the FDA. This research would need to establish that individuals can understand a Drug Facts Label for medical abortion, assess gestational age as eligible and rule out other contraindications for medical abortion, self-administer the medications according to instructions, and identify complications or need to seek medical care, including for ongoing pregnancy. In the short term, these efforts will help support a wide variety of efforts aimed at improving access to clinic-based medical abortion, and in the long-term, support regulatory approval for an OTC product.

CS7.3

Smartphone technology: increasing access to abortion information and support

Caitlin Gerdts, Ibis Reproductive Health, United States

Smartphone applications (apps) have been shown to increase health knowledge and agency, and to improve medication adherence and health outcomes. Given increasing restrictions on access to abortion and reproductive health services in the US and around the globe, new technologies that expand access to information about and support for comprehensive sexual and reproductive health issues, including abortion, are needed.
In partnership with safe abortion hotlines, abortion clinics, reproductive justice organizations, and advocate colleagues, Ibis Reproductive Health has conducted formative research examining user needs and preferences for such a smartphone app in Indonesia, Mexico, and the U.S. Formative work has demonstrated that smartphone apps are desirable across a range of contexts, and apps that provides comprehensive SRH information, including information on abortion, delivered through a supportive and secure platform, are needed. Users want an app that can be tailored to their current reproductive health realities and can be modified to meet changing needs throughout their reproductive lives. We will additionally share preliminary findings from a randomized control trial conducted in partnership with Samsara, a safe abortion hotline in Indonesia, to evaluate feasibility and acceptability of a smartphone app that provides information and support for women self-managing medication abortion.

CS9.1

Feticide prior to second trimester abortion: how to end a fetal life

Richard Lyus, Homerton University Hospital, United Kingdom

The RCOG stipulates that 'Feticide should be performed before medical abortion after 21 weeks and 6 days of gestation to ensure that there is no risk of a live birth.' Live birth is to be avoided for 'emotional, ethical, and legal reasons.' But live births happen with medical abortions at earlier gestations and can occur prior to surgical abortions in the second trimester if labour is precipitated by cervical preparation agents. Furthermore, the very same emotional and ethical matters apply to surgical termination in the second trimester, because the same questions are raised regarding how best to end both a woman's pregnancy and a fetal life. I argue that if there are compelling reasons to perform feticide prior to second trimester medical termination, the reasons are even more compelling prior to surgical termination. Both women undergoing abortion in the second trimester and their care providers should have the choice of using feticide, regardless of the method chosen.

CS9.2

Ask the experts: difficult cases in medical and surgical abortion

Oona Nyytäjä, Finland - Richard Lyus, United Kingdom - Matthew Reeves, United States - Paul D. Blumenthal, United States - Ingrid Sääv, Sweden

Wondering how to manage second trimester medical abortion or dilation & evacuation in the setting of an abnormally implanted placenta?

Looking for advice on advancing the gestational age at which you and your team provide? Have questions about cervical preparation, offering a choice of method, managing prolonged inductions, or anything else related to medical or surgical methods of abortion after the first trimester? Bring your questions along to this panel of five leading experts in second trimester abortion care. Experienced, new and curious providers are all welcome to contribute to what should be a lively and wide-ranging discussion.

CS10.2

Assessing quality of care in abortion: focusing on the client experience

James Newton, IPPF, United Kingdom

IPPF monitors quality of care throughout its abortion programme in order to assess and improve clinical service delivery. However, the current measures are largely focused on clinic and staff capacity, and do not fully capture the client's perspective of abortion care beyond broad measures of satisfaction. IPPF aimed to explore women's perception of quality abortion services to better understand their concerns and priorities. In collaboration with Ibis Reproductive Health and IPPF's Member Associations in India and Kenya, data was gathered from women who had previously obtained abortion services. 24 women in Kenya were interviewed, while in India 10 women were interviewed and 11 took part in two focus group discussions. A structured set of questions was developed and refined to elicit responses on what women felt comprised a good quality abortion, how they felt about the abortion care they received and the impact of abortion-related stigma on their experience. These responses were coded and analysed by Ibis. Results showed that women in both countries had low expectations of the abortion experience before their procedure, had little knowledge of what it would involve and feared pain, dangerous side-effects and stigmatising treatment from providers. Aspects of care mentioned as most important included kind and polite staff, a successful and safe procedure, and clear explanations to prepare clients. IPPF will use these findings to inform its abortion programme and improve quality in abortion care. Abortion quality of care monitoring will be refined so that these dimensions of quality are adequately captured and measured. This will involve developing indicators that focus on these concerns and integrating these into client exit interviews and other methods of monitoring.

CS11.1

Accessibility of abortion services: policy versus reality (example from Georgia)

Nino Tsuleiskiri, Association HERA XXI MA Georgia IPPFEN, Georgia

In Georgia during last decade medical service providers became decentralized and universal health care provision were launched. These changes in health system triggered increase in number of health providers and proportionally need for regulation of service provision and financing.
Non-preventable abortion in Georgia is legal and provision of service is distributed to primary and secondary health providers. Law of Georgia on health care allow abortion on request up to 12 weeks of gestation therefore mandates 5-day mandatory waiting time between consultation and abortion procedure. State policy regarding abortion is to increase childbirth while women's choice and health is unsatisfactory level.

Despite liberal policy there still is low accessibility and availability to safe abortion services which is caused by uneven distribution of service providers that provide abortion service, ununiformed referral system, and diminishing number of abortion provider physicians (church influence, conscientious objection). As a result, women are forced to travel for service.
In Georgia unsafe abortion is widespread in spite of medical activity regulation on physician and medical facility levels. Due to no medical service quality appraisal, it is impossible to track standards of service provision and identify medical facilities where quality is not sufficient. For example, system does not track service providers where only D&C method is used or how frequently it is used. If consider D&C method, along with general anesthesia, no counseling, no post-abortion family planning and etc. as unsafe way of abortion service provision. Two above-mentioned issues make it difficult to prevent unsafe abortions.
Women searching for abortion services encounter accessibility and availability barriers that are Not enough Abortion Providers, Cost and Travel, Judgmental Gatekeepers, Conscience Clauses, Bad Referrals, Anti-choice Organizations (church), which makesprevention of unintended pregnancy difficult, leading to high abortion rates, low quality.

CS11.3

Partnering with young people as champions in sexual rights and abortion access

Kader Avonnon, ABPF/IPPF, Benin

In West Africa, the number of deaths due to unsafe abortion is 540 per 100,000 unsafe abortions. In Benin, legal restrictions and prevalent stigma create barriers to access for safe abortion.
Since 2014, the IPPF Member Association in Benin, Association Béninoise pour la Promotion de la Famille (ABPF) has implemented a project aimed at reducing abortion stigma amongst young people. An adapted “Stigmatizing attitudes, beliefs and actions scale” (SABAS - Shellenberg, 2014) implemented to measure community attitudes to abortion, revealed that 84% of respondents have a negative perception of abortion and they do not favour access to safe abortion services. Young people often use unsafe methods of abortion because of stigma they face in the community. The double stigma of being sexually active and seeking abortion care experienced by young people disempowers and leaves them without accurate information and support, increasing the risk of unsafe abortion.
Through the project, ABPF has empowered young people to lead initiatives to reduce abortion stigma. ‘Youth Champions’ have been trained on abortion rights and they work with their peers, providing information about sexual health and abortion, and refer young people to clinics for safe abortion services. Some specific strategies that the youth champions have implemented include conducting outreach activities in schools, with students and teachers as well as specific sessions for young people that are out of school. The Youth Champions have conducted advocacy with community leaders to influence policies in support of young people’s access to safe abortion services. The Youth Champions are active on social media, answering questions from other young people and working to destigmatize abortion. Since October 2016, the number of abortion and abortion related services provided to young people is 4561, in addition the Youth Champions have referred 153 young people themselves to ABPF services

CS12.1

Early medical abortion available but not offered in Bulgaria

Andriana Andreeva, British Pregnancy Advisory Service, United Kingdom

Medical abortion in Bulgaria is available in unusual circumstances. Abortion in Bulgaria is allowed up to 12 weeks upon wish, up to 20 weeks - for medical conditions or foetal anomalies, and after that - in extreme circumstances.
The legislation regarding abortion has been made in 1990 and last reviewed in 2000. Medical abortion doesn't exist in it. It is written envisaging surgical procedures only. It requires blood tests (FBC, MSU, clotting, blood group, Rh) and vaginal swab prior to every abortion. It also requires the abortion to start and end in a medical facility. It otherwise classifies the act as a criminal offence and envisages imprisonment of up to 5 years and if repeated - up to 8 years.
Medical abortion, however, has been performed in the country over the past 10 years or so. Prior to the official availability of registered drugs, Cytotec was in wide circulation. It still is, regardless of the lack of registration in the country.
Mifepristone and Misoprostol have been first registered in 2012, reaching the market in the end of 2014. Their registration is for distribution in pharmacies, by prescription. The obs&gynae society, however, is largely against the wide availability of the medications, being afraid women will self medicate, and are reluctant to prescribe them, seeing it as illegal to participate in abortion outside medical facility. Very few hospitals offer MTOP or medical management of miscarriage as an inpatient procedure. Professional knowledge on medical abortion is limited. It is widely believed that *every pregnancy must end with delivery or curettage*.
A few hospitals and doctors do provide medical abortion, albeit in variation of regimens, and more and more women request it.
It is because of women's increasing interest and the few doctors fighting for the cause, that medical abortion is surviving in Bulgaria.

CS12.2

When there is no one left to care for women with complex medical conditions

Janesh Gupta, Birmingham Women's and Children's Hospital, United Kingdom

Since 2015, we have developed and set up a regional complex abortion service up to 20 weeks gestation. The future would be to expand this service to the legal gestation age of 23+6 weeks. This service has exponentially expanded over the past 3 years to cater for women with complex co-morbidities, which require a multi-disciplinary team involvement. I shall present the unit's case load, complexities and methods of achieving a safe outcome with the focus for ensuring a high uptake of long acting reversible contraceptives.

CS12.3

Access issues across Australia

Deborah Bateson, Family Planning NSW, Australia

Australia is a prosperous country which endeavours to provide equitable access to high-quality healthcare. Yet this is not the case for abortion.

With the introduction of government-subsidised medical abortion in 2013 it was envisaged that women would be able to access affordable abortions, medical or surgical, across the country. Unfortunately, this promise has not been met, especially for those who are financially disadvantaged or who live in rural and remote areas.
Australia has a complex patchwork of abortion laws across its 8 states and territories, ranging from legal abortion available on request up to 24-weeks with potential supply of early medical abortion drugs by nurses in Victoria, to abortion provision still residing in the Crimes Act of 1900 in the most populous state of New South Wales. While decriminalisation has not always led to improved access, the risk of prosecution serves as a barrier to service provision, particularly in the public setting. Publically-funded hospital services, except for fetal abnormality, are difficult to access or non-existent in most states and territories and costs for private medical and surgical abortion services vary widely and can be substantial and unaffordable. While General Practitioners are potentially able to provide low cost medical abortion to their patients only a very small number do so due to perceived stigma, poor remuneration and concerns about managing complications in the absence of clear referral pathways into local hospitals. Australia's innovative telemedicine service has the potential to overcome barriers to access but reports of obstruction and psychological abuse of women by health care providers providing radiology and other necessary support services highlights that abortion is far from stigma-free in Australia. Despite these challenges key steps are being taken by professional colleges and other leading health organisations to integrate abortion care within their training pathways and in calling for policy reform focussing on reducing costs and enhancing early access.

CS14.1

Safe abortion in humanitarian settings

Maria Rodriguez, OHSU, United States

In recent years, conflict, violence and disasters have brought a dramatic rise in the number of displaced people, both within and across national borders. There are an estimated 26 million women and girls of reproductive age living in emergency situations, all of whom need sexual and reproductive health (SRH) information and services. The average length of time an individual now spends displaced is 20 years, and three quarters of countries with the highest maternal mortality ratios are fragile states as defined by the Organisation for Economic Co-operation and Development. Sexual violence is also prevalent. A recent Global Review demonstrated that significant gaps remain in access to safe abortion and reproductive health care in humanitarian settings.
Providers are an essential component of safe abortion care globally. In humanitarian settings providers have unique needs to provide safe, competent care. To support providers in offering safe, evidence-based reproductive health care, the WHO has recently developed a process for adapting reproductive health guidelines to the humanitarian setting, and developing provider tools. This process was developed following a review of the literature, and in consultation with experts in guideline methodology, emergency response, SRH and rights, epidemiology, implementation research, and program managers. The methodology has been applied to the Medical Eligibility Criteria for Contraceptive Use, and a tool of the adapted guidelines developed and field tested. Similar efforts may further provision of safe abortion care in the humanitarian settings.

CS14.2

Fulfilling our commitment to women and girls: Integrating safe abortion care into emergency response

Erin Wheeler, International Rescue Committee, United States

The International Rescue Committee, a multi-sector humanitarian response organization, has embarked on an ambitious strategy to enhance the quality and reach of our programs to help our beneficiaries achieve key outcomes. A central pillar of IRC2020 is achieving gender equality, which requires improved sexual and reproductive health outcomes for women and girls. The global evidence demonstrating that the burden of unsafe abortion falls most heavily on poor women and girls in low resources countries, many of which are affected by conflict and natural disaster, led the IRC to develop a strategy to integrate safe abortion care (SAC) into our programs. This strategy has four main objectives:

- Clarify our organizational commitment to increasing access to SAC;
- Transform staff attitudes toward SAC and the women and girls who request the service;
- Build context-specific knowledge around abortion in each country program; and
- Implement country program-driven approaches to increase access to SAC.

As a result of this strategy, three IRC country programs offer safe abortion care and an additional 9 are developing strategies to do so. The IRC's experience offers a road map and lessons learned for other organizations hoping to increase access to SAC and demonstrates that it is feasible to provide safe abortion care in humanitarian settings.

CS14.3

Research on safe abortion in emergency contexts

Bill Powell, Ipas, United States

Even as the climate for sexual and reproductive health funding and research has become more tolerant, abortion in humanitarian settings remains under-studied. Systematic reviews have documented significant limitations of funding for abortion-related research as well as evidence gaps on both the need for and provision of safe abortion in humanitarian settings. Additionally, many implementing and research institutions lack the networks, skills and/or time to conduct challenging research in this complex environment. Evidence is needed to generate and sustain interest, document the scope of the problem, and ultimately to help promote an agenda for bridging this gap and turning research into action to meet women's abortion care needs. This presentation will discuss the evidence gaps, types of needed research, promising partnerships, funding, and describe examples of on-going research and documentation.

CS15

Moral & ethical thinking: from global abortion providers, an interactive discussion

Willie Parker, United States - Eddie Mhlanga, South Africa - Laura Gil, Colombia - George Thomas, United States

Those who oppose legal and safe abortion often try to dominate the discourse on moral and ethical questions. CFC's contact with providers, doctors, nurses and other clinical workers in Asia, Africa and Latin America suggests strongly that providers do consider ethical and moral questions when they defend the right to or perform abortions. This workshop will bring front line providers from other parts of the world to a European audience and demonstrate how ethical and moral perceptions on abortion are intrinsic to service provision and an excellent rebuttal to those who seek to hijack language and arguments in this sphere.

Lunch sessions

LS1.1

Creation, implementation and impact of a Comprehensive Abortion Care Strategy in the Western Cape, South Africa

Valerie Truby, Western Cape Government, South Africa

Despite South Africa having one of the most progressive abortion laws in the world, unsafe and illegal abortions remain a significant public health problem. Multiple barriers to abortion care provision exist including provider conscientious objection, stigma, healthcare provider shortages, lack of trained providers, and a lack of designated facilities providing abortion services.
In partnership with the Western Cape Department of Health (WCDOH), the RCOG Leading Safe Choices (LSC) programme seeks to improve access to abortion services within the Western Cape by increasing the number of providers willing and able to provide Comprehensive Abortion Care (CAC) services; improving the quality of post abortion family planning counselling and provision; and raising the standing of abortion care professionals. The programme trains and mentors mid-level health care providers (HCPs) in CAC.
Early on in the LSC programme it became clear that although training interventions can make a localised impact in relation to increasing skilled providers and improving quality of abortion care, the overall impact was being hindered by the prevalence of conscientious objection at senior management levels; the failure of the WCDOH to hold designated facilities accountable if they failed to provide CAC services; blockages in the referral pathway of patients and a lack of understanding of multi-disciplinary teams to provide CAC services as women's rights enshrined in the Choice on Termination of Pregnancy Act and the constitution of South Africa.
In partnership with the WCDOH and using lessons learnt during the programme, a CAC Optimization Strategy was implemented to tackle systems barriers and to improve abortion care services. Following its implementation uptake of CAC training has tripled and 11 new CAC sites have been established in the Western Cape.
This presentation will present the different elements of the Western Cape CAC Optimization Strategy and its vital role in improving CAC services within province.

LS1.2

The Royal College of Obstetricians and Gynaecologists' Abortion Task Force

Patricia Lohr, British Pregnancy Advisory Service, United Kingdom

Before the 1967 Abortion Act, unsafe abortion was a leading cause of maternal mortality in the UK, responsible for 14% of maternal deaths. The Royal College of Obstetricians and Gynaecologists (RCOG) has identified as a key priority the need to ensure today's abortion services are sustainable into the future. Changes to the commissioning and delivery of abortion services have had a significant impact in recent years. The shift towards provision of abortion services by the independent sector has directly led to a reduction in the training opportunities and placements available to doctors working within the NHS. This has resulted in a smaller number of doctors with the requisite skills to deliver abortion care to women across the UK. The low prestige and stigma that can be associated with abortion care are also affecting morale within the profession.

To help overcome the challenges with the healthcare provider workforce, the RCOG has established an Abortion Task Force, led by the College President, Professor Lesley Regan. The Taskforce works collaboratively with the main independent-sector providers and engages with politicians to develop system-wide solutions to ensure that women have access to safe, sustainable, high-quality care.
This presentation will present the different elements of the RCOG's Abortion Task Force and its vital role in improving abortion services in the UK.

LS2.1

Progress in medical abortion in Thailand

Kamheang Chaturachinda, WHRRF, Thailand

Prior to 2002 Misoprostol was freely available over- the- counter in Thailand at a cost of US 40 cents each. In 2002 the Ministry of Health had the first ever female Minister. She was from an ultra- conservative religious right political party (Palang Dhama Party). This party viewed abortion as immoral and sinful. Misoprostol was therefore put on the restricted drug list that needed to be prescribed only in hospital by a physician. The cost of the tablet in the market rocketed from 13 Bahts (40 US cents) up to 2,500 Bahts (70 USD) and even to 5,000 Bahts (160 USD) per tablet. A combination of Mifepristone 200 mg and Misoprostol 800 microgram package (commercial name MEDABON) was introduced in to Thailand in 2009 by the Concept Foundation. This was first introduced in to 3 leading medical schools in Bangkok(and later in to Provincial medical schools) as a research project. The second phase research of the efficacy and effectiveness of MEDABON was launched by WHO and our Foundation (WHRRF) at Ramathibodi hospital in Bangkok in 2010. After the publication of this study, we vigorously pushed for the registration of the drugs in Thailand as well as listing in the essential drug list (EDL). Listing in EDL allows the National Health Security Office (NHSO) to obtain the drugs for use in the Women's Reproductive Health Entitlement Package at a reduced price. Registration was successful in 2014 . And listing in EDL in 2016. Medabon is now bought by the NHSO at a reduced price for distribution and use in the Women's Reproductive Health Entitlement Package free of charge (market price 500 B./package: NHSO price 230 B./package). Even though Medabon is registered for use to terminate pregnancy, Safe Abortion is still not universal available to women in Thailand. The main reason for inaccessibility of women in Thailand to medical termination of pregnancy is the negative attitude of the healthcare providers. WHRRF together with the Royal Thai College of Obstetricians and Gynaecologists are trying to overcome this obstacle by education and training.

LS2.2

After the referendum: abortion in Ireland

Caitriona Henchion, IFPA, Ireland

Ireland has one of the most restrictive abortion laws in the world: abortion is only permitted to save the life of the mother. That is about to change. In May 2018, by a referendum, the Irish people voted by a landslide majority to repeal the constitutional provision—the 8th amendment—that banned abortion and to empower the legislature to provide for abortion care in Ireland.

In 2017, a Citizen's Assembly, 99 "Citizens" chosen by a random selection process to provide a geographical, gender, age balance, overseen by a senior judge, was convened to hear evidence from a wide variety of sources – medical, legal, activists on both sides of the issue.
The very liberal legislative model recommended by the Assembly inspired a subsequent parliamentary committee—which in its turn heard form medical and legal voices—to also recommend legislation to permit abortion on broad grounds. This led the government to call a referendum to repeal the 8th amendment.
The presentation will focus in particular on the ways in which health expertise, international best practice and public health evidence became tools of human rights advocacy. It will discuss the role of the Irish Family Planning Association in developing and using these tools, and, critically, in building the capacity and creating a community of healthcare practitioners who would become key advocates in the campaign to repeal the 8th amendment.
The presentation will also outline the new legal framework being proposed by the government, potential barriers to access and inequities in the system proposed. Finally, the presentation will discuss the challenges that now present us as we finally become committed, rights-based providers of abortion care.

LS3.1

Abortion in Scotland – moving from stigma to positivity

Carrie Purcell, University of Glasgow, United Kingdom

This paper reflects on findings from several recent studies on abortion in Scotland. These have examined experiences of earlier/later abortion, more than one abortion, and of working in abortion provision. Together they constitute a rich body of data illustrating manifestations of abortion stigma; feelings which abortion may evoke (such as shame, disgust), and ways in which stigma is resisted/rejected. Qualitative secondary analysis of these data highlights that negative attitudes toward abortion continue to prevail - and to shape experiences of those seeking and providing it – but that positive accounts also emerge and merit further attention. Foregrounding positive accounts contributes to understanding of abortion stigma, and of what alternative orientations to abortion might look like, in a way that is grounded in women's lived experiences. Our analysis also suggests that, even in a context where it has been safely, legally provided for 50 years, women who have undergone abortion nevertheless find it difficult to escape cultural narratives which position it as highly negative and taboo. Our findings point to the need to further address abortion stigma and negativity head-on, and to collaboratively shift the narrative towards abortion positivity.

LS3.2

What role can community-based education play in challenging abortion stigma?

Fiona Bloomer, Ulster University, United Kingdom

Objectives: In societies with oppressive anti-abortion norms, such as Northern Ireland, little is known about how these norms are resisted by the adult population. This paper explores how resistance to religious and patriarchal norms can be fostered through adult community abortion education; and considers how such knowledge can inform engagement with those seeking and providing abortions.
Methods: Participants (n=17) of a community-based abortion education programme were interviewed to explore their views on abortion utilising semi-structured interviews.

This paper focuses on a thematic analysis of the interview data, with a particular focus on how women resisted oppressive norms and the stigmatised positioning of abortion.
Results: The findings indicate that this resistance is multi-faceted and bolstered by a lived experience discourse, which does not necessarily involve eschewing religious notions held within society.
Conclusions: Meanings of abortion in society are constructed within socio-historical and gendered spaces and manifested through myriad discourses that impact on the perception and treatment of the issue in that society. The paper concludes that adult abortion education in community settings offers the possibility of creating dialogical spaces for people to reflect on and resist oppressive norms regarding reproduction and abortion, and in so doing can challenge stigma more broadly. (drawn from article Bloomer, O"Dowd, Macloed, 2014)

LS3.3

Towards understanding internalised abortion stigma: listening to women's voices

Lesley Hoggart, The Open University, United Kingdom

This presentation seeks to generate understandings not only about how women may internalise abortion stigma; but also about how that internalisation may be resisted and rejected. It does this by drawing on a qualitative secondary analysis of young women's narratives in two abortion studies in England. The analysis showed that whilst most women did internalise abortion stigma, many resisted this stigmatisation, and some rejected it. Individually-held moral views interacted with socio-cultural norms around reproduction and motherhood, and shaped women's responses to their abortion. Stigma management strategies were grounded on rejecting notions of blame, and or feelings of shame. Those women who were morally confident about their exercise of bodily autonomy were least likely to struggle with their decision-making or to experience negative post-abortion emotions. The analysis showed that abortion-related stigma is neither universal nor inevitable, and indicates that attempts to normalise abortion may help women avoid internalising abortion stigma.

LS1.1 (Saturday)

Repeated pregnancies in adolescents

Kai Haldre, East-Tallinn Central Hospital Women's Clinic, Estonia

Majority of research about the protective and risk factors of repeated teenage pregnancy has been carried out in the US. Worldwide, there is more information available about subsequent adolescent deliveries than abortions. The main reason here is that the availability and quality of abortion statistics vary largely in countries. In many countries with restrictive laws abortion statistics hardly exist. Estonia is considered to be a country with liberal legislation and complete abortion data since 1992. From the same period, after regaining independence from Soviet occupation in 1991, Estonia has undergone major socio-economic changes including profound educational and health care reforms. According to the World Bank Analytical Classification of countries Estonia has turned from upper/lower income country in 1990-ies to high-income country since 2006.
The objective of this presentation is to analyze trends in adolescent pregnancies in Estonia from 1992 until 2017 and the proportion of repeated pregnancies from 1996 until 2017.
Methods. Data on abortions were obtained from the Estonian Medical Statistical Bureau (1992–1995) and the Estonian Abortion Registry (EAR, 1996–2017).

The completion and return of an anonymous record card to the EAR for each abortion is obligatory for every institution licensed to perform pregnancy terminations. Data about births were obtained from the Estonian Medical Birth Registry, which was established in 1992. The number of women in the 15–19-year age group was obtained from the Statistical Office of Estonia.
Results. The percentage of teenage mothers from all parturients was 14.6% in 1992 and 2.0% in 2017, the proportion of adolescents from all women terminating pregnancy was 11.4% in 1992 and 7.2% in 2017. During the same period teenage abortion and fertility rates have decreased 81.7% and 79.8% respectively. In 1996–2017 the average proportion of teenage abortion patients with repeat abortion has been 18%, over the years no clear increasing or decreasing trend can be observed (lowest 15.8% in 2005 and highest 22.3% in 1996), the same is true concerning delivery before the index abortion (average 16.1%, lowest 13.0% in 2015 and highest 20.4% in 1996). In average, 8.4% of teenagers were multipara during 1996–2017 (lowest proportion - 6.0% - in 2005 and highest in 2015 - 11.8%).
Conclusions. During the period of remarkable changes in the Estonian society and economic growth teenage fertility and abortion rates have decreased substantially and become a rather rare event. During the study period a little less than one fifth of teenage abortion patients have experienced previous delivery or abortion, around one tenth of teenage parturients are multipara. Thus the proportion of repeated pregnancies among adolescents has remained the same.

LS1.2

Timing of IUD insertion after abortion

Roberto Lertxundi, Clinica Euskalduna, Spain

The scientific community emphasizes the evident need to utilize an effective contraceptive method as rapidly as possible following an abortion. After surgical procedure: There is no question in regards to the convenience of inserting intrauterine contraceptives immediately after a surgical termination, if the woman so desires. Like many other groups we offer this presentation with 250 IUD inserted immediately after a surgical termination, at the end of the procedure through out 2015 and 2016. The results after a year of follow up, are equivalent to others that are usually published on the the subject of continuation, expulsion, failure and satisfaction of the IUD. When shall the IUD be inserted following a MToP? In our opinion, as soon as possible, that is, in the first follow up visit after the procedure. There is no benefit in delaying the insertion. Therefore we refuse the notion of delayed insertion (3-4 weeks after the abortion) and we recommend an early insertion (between 5 and 14 days after the MFP intake.) Often, the follow up visit is the only opportunity for the patient to begin using an adequate contraceptive. The benefits of LARC over SARC are evident. We will present a study of the early insertion of 115 IUD after MToP through out 2015 and 2016. The results, as we will prove, are similar to in IUD users in general.
Our recommendation:
-Insert the IUD as soon as possible
-Take advantage of the opportunity of follow up visit
-Let none leave the follow up visit without an adequate contraceptive.
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LS1.3

Contraceptive use after cancer

Gabriele Merki, University Hospital Zürich, Switzerland

Unintended pregnancy can disrupt treatment and recovery for women of reproductive age with cancer. Although some cancers and treatmentss impair infertility, many women with cancer are physically capable of conceiving. Little is known about contraception counseling and abortion in cancer care. Several studies indicate that cancer surviviors in different countries have more abortions than their siblings. Women are overloaded with information at cancer diagnosis adn fertility isues are freuqently forgotten. In a Swiss study of reproductive-aged women with breast cancer 62 of 100 participants needed contraception counseling at time of cancer diagnosis. 17% of women in an Australian sample never had the question: *What should I do about contracpetion* ? answered during their cancer care. Also some women believe that they could not get pregnant during and after treatment, despite having no clinical diagnosis of infertility. One study found that women who had contraceptive counseling had alomost even times higher use of effective contraceptive methods. A US study demonstrated a higher use of emergency contraception among female young adult cancer survivors. In conclusion using contraception to time pregnancies for periods of better health, is highly relevant for women with a recent cancer diagnosis. Improving reproductive health care for women with cancer is essential. Collaboration between healthcare providers couselling involved into cancer treatment and family planning doctors/nurses/midwifes needs improvenment.

Free communications

CS1

FC.01

Experiences of Irish women seeking abortion care in the United Kingdom

Joanna Mishtal, University of Central Florida, United States; Patricia Lohr, British Pregnancy Advisory Service, United Kingdom

Objectives: We examined experiences of women who travel from the Republic of Ireland to the UK for abortion care. Irish women's experiences are poorly understood. Publically shared stories tend to highlight cases of tragic circumstances (e.g., foetal anomalies, minors), eclipsing more ordinary circumstances for seeking abortion. We collected data about experiences of the latter group by using a systematic qualitative research approach.
Methods: Qualitative data were collected using In-Depth Interviews (IDIs) with 25 Irish women who traveled to Liverpool and London for abortion care between February and June 2017. Participants were Irish citizens or permanent residents and received surgical or medical abortion. We excluded minors and foetal anomaly cases. Participants' age ranged from 19 to 43 years old; 18 of 25 participants were in their 20s. Their reported gestational age was between 6 and 19 weeks. IDIs followed a 13-item Interview Guide with semistructured probes. Topics included: arranging travel, challenges, support network, delays, and privacy.
Results: Data reveal significant hardships in women's experiences traveling abroad for abortion care, including difficulties arranging travel in an "environment of secrecy" despite readily available information online, maintaining privacy in social and professional circles while waiting to travel, financial constraints, getting time off work, and securing overnight childcare. Financial barriers may lead women to intentionally schedule later appointments to allow time to organize money. Women who borrowed money reported getting bank loans of 900-1500 Euro. Additionally, the use and location tracking capabilities of social media (Facebook, Snapchat, etc.) may generate added stress about retaining privacy in abortion travel.
Conclusion: Irish women who travel for abortion care to the UK overcome significant financial, social, and employment difficulties in a burdensome environment of secrecy in order to pursue abortion services abroad. This study highlights the need to liberalize access to abortion care in Ireland.

FC.02

Can women accurately assess the outcome of medical abortion based on self-assessment and low sensitivity urine pregnancy test?

Céline Pimentel, CHU Rennes, France; Vincent Lavoue, CHU Rennes, France; Simon Girault, CHU Rennes, France

Background: The failures of medical termination of pregnancy (MToP) can have serious consequences such as exceeding the legal age of abortion and the occurrence of fetal malformations related to the teratogenic action of misoprostol.

Objective: To study the correlation between a low-sensitivity urine pregnancy (LSUP) test associated to a self-performed questionnaire and the standard patient follow-up after MToP, consisting of a clinical examination, a blood hCG test and ultrasonography when needed. Methods: Prospective cohort study included women who came to their post abortion visit after MToP from March to August 2017. They performed a LSUP test and a self-performed questionnaire to assess their opinion on the completion of the abortion. Then a standard follow up was done by a doctor. A successful MToP was defined as a complete uterine abortion, with no the need for surgical intervention or for new abortive medication. Results: 133 women have been included in this study. The rate of successful MToP was 94.0%. Regarding failures there were two ongoing pregnancies (1.5%) and six retained products of conception (4.5%) treated either by a surgical procedure or with a new oral administration of misoprostol. Sensitivity of the womens opinion combined to the LSUP test was 100%, specificity was 89.6%, positive predictive value 38.1%, negative predictive value 100%, a Youden index of 0.89 and a kappa coefficient of 0.51. Conclusion: Given the extremely high efficacy of MToP, most women do not need a clinical follow-up to confirm pregnancy termination. Our data show that most women can ascertain their abortion outcome using a simple self-administrated questionnaire and a LSUP test.

FC.03

Cross-country travel for abortion in Europe: Costs, barriers, and delays to care

Caitlin Gerdts, Ibis Reproductive Health, United States; Silvia DeZordo, University of Barcelona, Spain; Giulia Zanini, University of Barcelona, Spain; Ann-Kathrin Ziegler, University of Barcelona, Spain; Joanna Mishtal, University of Central Florida, United States; Giulia Colovolpe Severi, University of Barcelona, Spain

Objectives: Existing data suggest that European women from countries with relatively liberal abortion laws travel to other European countries for abortion care, yet, few studies have described this unique experience. Methods: We analysed preliminary data from a five-year mixed method study conducted in the UK and the Netherlands. We examined characteristics of women travelling for abortion services from France, Italy, Germany, and other EU countries. We present results from 127 self-administered surveys collected in the UK (n=41) and in the Netherlands (n=86). From our data we identify main barriers to abortion care, estimate the costs incurred, and describe delays women experienced in the process. We contextualize these findings using data from in-depth interviews. Results will be updated based on the most up-to-date data. Results: Patients incurred large out-of-pocket costs. Only 5% of respondents in the Netherlands and 2.5% in the UK had the costs of the abortion procedure fully or partially covered by insurance and all clients incurred additional travel costs. The majority of participants were in their second trimester of pregnancy. On average, clients had considered an abortion over a month before their scheduled procedure, and almost all wanted to access abortion earlier in their pregnancy, but were delayed because they did not know they were pregnant and/or there were no abortion services near their residence. The main barriers to abortion services included surpassing the gestational age limit in their country of residence or not meeting the legal requirements. On average, clients travelled 3-6 hours to access services in the UK and the Netherlands. Conclusion: Women throughout Europe experience legal, social, and procedural barriers to abortion services in their countries of residence that cause them to have to travel for abortion services abroad. Women incur high costs in travelling for abortion services and in many cases are delayed in accessing wanted abortion services

FC.04

Supporting safe managed abortion in Poland and the USA: what is the difference?

Kinga Jelinska, Women Help Women, Netherlands; Susan Yanow, Consultant, United States; Justyna Wydrzynska, Kobiety w Sieci, Abortion Dream Team, Poland; Karolina Wieckiewicz, Abortion Dream Team, Poland; Natalia Broniarczyk, Abortion Dream Team, Poland

In Poland, abortion is legally restricted. Yet there are underground abortion providers and many who have an unwanted pregnancy receive abortion pills through telemedicine services. Those who advocate abortion face threats and harassment by anti-abortion thugs and by the government, yet throngs of people have filled the streets. In the USA, abortion is legal but increasingly inaccessible to many, although there is at least one clinic in every state. There are networks of community-based providers and evidence that increasing numbers of people are choosing to manage their abortions with pills obtained through a range of sources, but 18 women have been arrested. In both countries, there are activists working to put abortion pills in womens hands and de-stigmatize the practice of self-management and the language around home use of abortion pills. On this panel, a member of the Polish Abortion Dream Team, the Director of Women Help Women and a member of the USA project SASS (Self-Managed Abortion, Safe and Supported) will discuss the parallels and lessons learned in their work, both from advocacy and security and activism perspective, that may be relevant for the pro-choice movement at large.

FC.05

Pain during medical abortion in early pregnancy - teenaged compared to adult women

Venla Kemppainen, Helsinki University hospital, Finland; Oskari Heikinheimo, University of Helsinki and Helsinki University Hospital, Finland; Maarit Mentula, University of Helsinki and Helsinki University Hospital, Finland

Context: The method of abortion has rapidly changed from surgical to medical termination of pregnancy (MToP) in several countries; today 95% of abortions are MToP in Finland.
Objective: Intensity of pain, need of analgesics, evaluation the adequacy of ibuprofein and paracetamol, and patient satisfaction. Comparison of teenagers vs. adult women. These are the results of an interim analysis of the first 97 patients of the study.
Methods: This prospective study evaluates pain during MToP in early pregnancy (<64 days of gestation). Altogether 120 primigravid women are being recruited. The ratio of teenagers (15-19 year-olds) and adult women (25-35 year-olds) is 1:1.
MToP was carried out according to the Finnish national guideline. The medication consists of 200mg of mifepristone administered at the outpatient policlinic followed by 0,8mg of misoprostol vaginally or orally at 24-72 hours primarily at home. Ibuprofein (600mg) and paracetamol (1g), both up to three times/day were used for pain management. First doses are taken simultaneously with misoprostol and thereafter whenever needed. Pain is measured by visual analogue scale (VAS), which is reported in a diary each time patient needs analgesics.
Results: The highest pain reported by VAS was 78±18 (mean±SD) among teenagers and 66±27 among adult women (p=0,005, VAS 70-100mm); 48% vs. 19% of the patients reported severe pain. Nevertheless 77% of teenagers and 65% of adults evaluated the analgesia as adequate and the overall satisfaction with the care received was high in both groups (VAS 85±12 vs. 85±15; p=0,311).

Altogether 88% vs. 93% would choose MToP again.
Conclusions: Women and especially teenagers undergoing MToP experience strong pain already in early pregnancy. Even though teenagers experience more pain they more often estimate that the combination of ibuprofein and paracetamol is adequate.

FC.06

Multiple abortions: The experiences of the women who request them and the staff who provide them

Christine McKnight, Aneurin Bevan University Health Board, United Kingdom; Jane Meyrick, University of the West of England, United Kingdom

Aim: To explore women's experiences of returning for subsequent abortions and the experiences of staff who provide abortions.
Background: While overall abortion rates are decreasing in the UK, the percentage of women undergoing more than one abortion has increased. Between 2006-2016 there was a 6% increase in the number of women requesting repeat abortions, rising from 32% to 38% despite historical improvements in medical interventions for contraceptive technology. Previous quantitative research has focussed on what is different about women who request multiple abortions and how to get them to uptake and adhere to long acting reversible contraception. Rather than their personal experiences.
Methodology: Qualitative semi structured interviews with 10 women who have had multiple abortions and 12 semi structured interviews with staff who work in an abortion service. All interviews were transcribed verbatim. Interviews were analysed using thematic analysis.
Results: Four overarching themes emerged which were guilt, shame, coping and perfect contraception. Women experience guilt at multiple levels from the legal framework, to service and individual level; whereas staff struggle with their own guilt regarding provision of services. Stigma is expressed in the language used, by both women and staff, surrounding abortion and by the issue of woman returning for multiple procedures. Coping describes the different ways that women coped with their abortions and how they coped differently with each one, examining how patterns of behaviour may emerge. Accounts evidence a sense of deep shame around returning for abortions which links closely with guilt where both women and staff apportion and internalise blame.
Conclusions: Abortion is a stigmatised medical procedure for both women and the staff who provide them. Women and staff use a variety of mechanisms to reduce that stigma some of which may fail to address ongoing problems with contraception. However, women who return for multiple abortions are diverse and so are their experiences, procedural and service issues may need to re-examine implicit attitudes to abortion.

FC.07

Immediate vs. delayed levonorgestrel-releasing intrauterine system insertion after medical abortion long-term satisfaction

Riina Korjamo, University of Helsinki and Helsinki University Hospital, Finland; Oskari Heikinheimo, University of Helsinki and Helsinki University Hospital, Finland; Maarit Mentula, University of Helsinki and Helsinki University Hospital, Finland

Objective: To analyze long-term satisfaction to intrauterine contraception after medical induced abortion.

Minimizing delay from medical abortion procedure to insertion of intrauterine contraception is a new approach to increase intrauterine contraception uptake and reduce subsequent unplanned pregnancies. Effect of this immediate insertion on womens satisfaction and quality of life is unknown. Materials and methods: Subanalysis of a randomized controlled trial. Total of 267 women were randomized to receive levonorgestrel-releasing intrauterine system (LNG-IUS, Mirena, Bayer, Turku, Finland) immediately (?3 days) or later (2-4 weeks) after medical induced abortion during January, 2013 December, 2014 in Helsinki University Hospital, Finland. Selected demographic factors were collected. Women answered questionnaires concerning satisfaction and quality of life at follow-up visits three months and one year after LNG-IUS insertion. Results: Following three post-randomization exclusions, there were 264 participants. Of the immediate-insertion group 98/133 (73.7%) and the delayed-insertion group 78/131 (59.5%) women returned to the 3-month follow-up, and 89 (66.9%) and 63 (48.1%) to the 1-year follow-up. Median age was 27.8 (IQR 23.033.1) vs. 27.3 years (22.532.1), p=0.54. At 3-month visit the immediate-insertion group was more often satisfied or very satisfied with their contraception compared to the delayed-insertion group (89 [89.9%] vs. 61 [79.2], p=0.048). We found no difference at 1-year (71 [79.8%] vs. 47 [74.6%], p=0.45). Womens experienced health, as measured by visual analogical scale (0100 mm), at 3-month visit was 84 mm (median, IQR 77 91) vs. 87 mm (7795), p=0.19, and at 1-year visit 85 mm (7493) vs. 86 mm (7492), p=0.75. Conclusion: Immediate LNG-IUS insertion following medical abortion did not have a long-term effect on womens satisfaction with intrauterine contraception or experienced health. Loss-to-follow-up rate was high and may have produced a selection bias. However, these results endorse the feasibility of immediate initiation of intrauterine contraception following medial abortion.

FC.08

Results from a randomised controlled trial of an mHealth intervention to increase post-menstrual regulation contraceptive use in Bangladesh

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Kathryn Church, Marie Stopes International, United Kingdom

Objectives: In Bangladesh, women undergoing menstrual regulation (MR) (an approved procedure to regulate menstruation in women at risk of pregnancy) are a key group to target with contraceptive services. We used a randomised controlled trial to evaluate an intervention delivered by mobile phone which was designed to promote contraceptive use among MR clients in Bangladesh.
Methods: In 2015/2016, we recruited 972 women after their MR procedure from 41 facilities, and randomised them to intervention or control groups. The intervention group were sent 11 automated, interactive voice messages with optional call centre counselling over 4-months post-MR. The primary outcome was self-reported LARC (long acting reversible contraceptive) use at four months post-MR; secondary outcomes were use of any effective modern method, subsequent pregnancy or MR and intimate partner violence (IPV).

We used Logistic regression modelling to calculate odds ratios, allowing adjustment for baseline differences between the groups among pre-defined variables. In 2017, we conducted in-depth interviews (IDIs) with 30 trial participants to explore the intervention effects/non-effects.
Results: We interviewed 773 participants (80%) at 4-months. Full details of the results from the trial and IDIs will be presented at the conference. Many IDI participants reported that they learnt more about contraception from the intervention however some women faced barriers to accessing the automated content due to low phone literacy. IDIs indicated a high frequency of phone sharing and that women's phone use is sometimes monitored or controlled by others in the home. The majority of IDI participants had told their husbands about the study and their MR.
Conclusions: These findings highlight the importance of considering familial contexts when designing interventions that reach into homes. The results of this trial will help us to understand whether this type of intervention can be successfully translated to the Bangladesh context.

FC.09

Intrauterine Mepivacaine for pain relief at IUD insertion

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Objective: To evaluate whether intrauterine instillation with Mepivacaine (Carbocain) before insertion of an intrauterine contraceptive device (IUD) decreases pain at insertion compared with placebo (NaCl). Design: Double-blind randomized controlled trial. Setting: Two outpatient clinics providing contraceptive services. Population: Women over 18 years of age opting for IUD for contraception. Methods: Women were randomized to intrauterine instillation of Mepivacaine (intervention) or placebo (placebo, NaCl) with a hydrosonography catheter before insertion of an IUD. During the procedure, women marked their pain on a 10-cm visual analogue scale (VAS). Data were analyzed by intention to treat, using descriptive and inferential statistics. Main outcome measures: Difference in pain score (VAS) at the time IUD insertion between intervention and placebo group. Results: A total of 86 women were randomized. Mean VAS-score was 4.63 in the intervention group (n=41, SD=2,21) compared to 5.67 in the placebo group (n=40, SD=2,62, P = 0.058). The intervention did not have a significant influence on pain but had a significant influence on the overall experience of the procedure (P = 0.003). Conclusions: Intrauterine instillation of Mepivacaine prior to IUD insertion did not significantly affect the pain score but had a significant influence on the overall experience of the procedure. Our findings support further studies with larger sample sizes.

CS8

FC.10

Risk factors for surgical intervention of early medical abortion and their predictive value: a nationwide prospective cohort study

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Objective: To assess the influence of gestational age, maternal age, and reproductive history on the risk for surgical intervention of early medical abortion.
Methods: A nationwide cohort study with eight weeks follow-up of all medical abortions induced at a gestational age <63 days among Danish women through the years 2005-2015. A multiple logistic regression model provided adjusted odds ratios (OR) with 95% confidence intervals (CI) for all the potential risk factors of interest. A division of the data into a training and validation set provided a test of the prediction performance of the model. Reported is the area under the receiver operating characteristic curve (AUC) with 95 % CI.
Results**:** 86,437 medical abortions were included, 5,320 (6.2%) were surgically intervened. The risk of surgical intervention increased with increasing gestational age ($p<0.0001$). The risk of surgical intervention peaked among women aged 30-35 years and declined for lower and higher ages ($p<0.0001$). The OR of surgical intervention among parous women compared to nulliparous was 2.0 (1.7-2.4) for women with a history of failed birth of placenta, 1.5 (1.3-1.6) for women with previous caesarean section, and 1.1 (1.0-1.2) for women with previous vaginal births with spontaneous birth of placenta. A history of early surgical abortion implied an OR of surgical intervention of 1.5 (1.4-1.7), and women with a previous late surgical abortion had an OR of 1.2 (1.1-1.3). Previous medical abortion implied an OR of surgical intervention of 0.84 (0.78-0.90). The AUC was found to be 0.63 (0.62-0.64).
Conclusion: In addition to gestational age, our study shows maternal age, previous delivery, and history of induced abortion to be risk factors for surgical intervention of early medical abortion. However, all these risk factors do not predict surgical intervention well, possibly indicating the subjective nature of the decision to surgically intervene a medical abortion.

FC.11

Implementing and expanding safe abortion care: an international comparative case study of six countries

Mary Favier, Global Doctors For Choice, Ireland; Wendy Chavkin, Global Doctors For Choice, Ireland

Objectives: The objectives of this study are to describe the health sector's role in establishing or expanding abortion services following legal or policy reform, and to compare strategies used in order to generate practice-based options for the implementation of abortion services.
Method: This is a comparative case study of six countries that recently changed abortion laws: Colombia, Uruguay, Portugal, Ghana, Ethiopia, and South Africa. For each, we completed a desk review of published and unpublished data, and conducted in-depth, semi-structured interviews with key stakeholders involved in the implementation of abortion services. Interview guides were tailored to each country, and stakeholders identified through a network of in-country partners.
Results: We conducted 58 interviews with healthcare providers, public health officials, academics, and members of advocacy groups. We found that specifics of the laws did not predict their successful implementation. Ministry of Health involvement was key. Collaborations with UN agencies and international NGOs helped establish clinical and training protocols. Integration of abortion into existing public facilities led to more rapid and broader access. Key strategic decisions included a focus on medical rather than surgical abortion; the expansion of midlevel providers' role; and integration of contraception into abortion care.
Conclusions: We observed a range of approaches to the implementation of abortion services in response to varying legal and policy frameworks.

Public sector commitment and early involvement was key to the successful establishment of services, and thoughtful adaptations to local contexts can significantly reduce logistical and financial barriers to the equitable provision of services.

FC.12

Two prophylactic medication approaches in addition to a pain control regimen for early medical abortion < 63 days' gestation with mifepristone and misoprostol: a randomized, controlled trial

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Objectives: To determine whether prophylactic administration of ibuprofen and metoclopramide or tramadol alone provides superior pain relief compared to analgesia when pain begins with mifepristone and misoprostol medical abortion through 63 days gestation. Methods: We conducted a multi-center randomized, placebo-controlled trial in Nepal, South Africa and Vietnam. Participants were randomized 1:1:1 to: (1) ibuprofen 400 mg and metoclopramide 10 mg ; (2) tramadol 50 mg and a placebo; or (3) two placebo, taken immediately before misoprostol and repeated four hours later. All women had supplementary analgesia to use as needed. Our primary outcome was maximum pain within 8 h of misoprostol administration. Secondary outcomes included maximum pain within 24 h, additional analgesia use, and medical abortion effectiveness. 86 women were required in each arm for 90% power to detect a 1.5 point reduction in maximal pain score using an 11-point visual analogue scale (VAS) compared to placebo; the sample size doubled to examine the effect of parity on the primary outcome. Results: 563 women (nulliparous n=275; parous n= 288) were randomized between June 2016 and October 2017. Women in both treatment arms reported lower pain scores compared to placebo (1: 6.43 (95% CI 6.10, 6.75); 2: 6.78 (95% CI 6.10, 6.75); 3: 7.42 (95% CI 7.10, 7.74). Ibuprofen and metoclopramide reduced scores more than tramadol compared to placebo (D mean 1: -0.99 (95% CI -1.45, -0.54); 2: -0.64 (95% CI -1.09, - 0.18); similar results were noted within 24 hours. Nulliparous women reported higher overall pain scores compared to parous women; but, treatment effect was similar. Women receiving prophylactic treatment generally used less additional analgesia. There was no difference in medical abortion effectiveness. Conclusion: Prophylactic ibuprofen and metoclopramide or tramadol reduced pain with medical abortion compared to placebo; ibuprofen and metoclopramide appears to offer better pain control compared to tramadol.

FC.13

Feasibility and acceptability of providing immediate postpartum intrauterine contraception (PPIUC) in a public maternity service

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Objective: Provision of immediate postpartum intrauterine contraception (PPIUC) is known to be safe but not routinely practiced within the UK. Improving access to effective contraceptive methods during the postpartum period can reduce the risk of subsequent unintended pregnancy and short inter-pregnancy intervals. Our aim was to introduce an immediate PPIUC insertion facility within a large public maternity service in Scotland, UK.
Methods: Obstetricians and labour ward midwives were trained in PPIUC insertion techniques. Women received PPIUC information from community midwives during routine antenatal contraception discussion. They could choose to receive either a copper intrauterine device or levonorgestrel-releasing system at planned caesarean section (from July 2015) or after vaginal birth (from January 2017). Women received a clinical review at six weeks to confirm device placement followed by telephone consultation at three, six and 12 months. Data from the first 300 women to receive intra-caesarean PPIUC and the first 100 women to receive PPIUC at vaginal birth were analysed in relation to complications, continuation and patient satisfaction.
Results: The uptake rate of PPIUC at caesarean section was 13.3%. There were 9 cases of suspected endometritis (3.8%), no uterine perforations and a cumulative device expulsion rate of 8.0%. At 12 months, the follow-up rate was 84.3% (n=253) and 79.1% (n=100) had continued IUC use. Of the first 100 women receiving PPIUC at vaginal birth, 45 (46.9%) experienced partial or complete expulsion and 82.2% proceeded to have further IUC inserted. There were no uterine perforations and 7 cases of suspected endometritis. At 3 months, 74.0% had continued IUC use. Median satisfaction scores were 10 out of 10.
Conclusions: It is feasible and acceptable to introduce immediate PPIUC insertion within a public maternity setting. There is a low rate of complications and patient satisfaction and continuation is high. The expulsion rate after vaginal PPIUC is likely to improve with increasing provider experience.

FC.14

Capturing compassion: support for abortion among Mexican Catholics by reason for abortion and degree of Catholicism

Stephanie Kung, Ipas, Mexico; Biani Saavedra-Avendano, CIDE, Mexico; Evelyn Aldaz Vélez, Católicas por el Derecho a Decidir, Mexico; María Consuelo Mejía Piñeros, Católicas por el Derecho a Decidir, Mexico; Gillian M. Fawcett Metcalfe, Católicas por el Derecho a Decidir, Mexico; Blair Darney, Oregon Health & Science Univ, United States

Objective: There is little consensus about whether commonly used measures of Catholicism lend much to our understanding of abortion support.

We tested whether degree of Catholicism was associated with support for abortion among Mexican Catholics and if different measures of Catholicism alter the relationship. Methods: We used data from 2,669 Mexican Catholics. Respondents were asked a question about support for legal abortion, as well as support for abortion under 10 exceptions, which we grouped into 2 categories: exceptions with traditionally majority (high) agreement and less than majority (low) agreement based on previous literature. Our independent variable was degree of Catholicism, measured in 4 ways: attendance at mass, degree of Catholicism, perception of a good Catholic, and confession after abortion. We ran multivariable logistic regression for our three outcomes, and separate models for each measure of Catholicism. Results: Perception of being a good Catholic was the only Catholicism measure that was significantly associated with all outcomes (legal abortion, high, and low agreement), controlling for covariates. Attendance at mass and self-identified Catholicism did not lend much beyond inclusion criteria. Respondents who believe a woman who helps someone who aborts can continue being a good Catholic had higher odds of support for abortion under high and low agreement exceptions. Respondents who believe a woman who aborts can confess to God or has no need to confess had higher odds of support for at least one low agreement exception. Conclusion: More nuanced measures of Catholicism that go beyond Catholicism as an identity are valuable in assessing support for abortion, especially exceptions with traditionally low support, which are the reasons most women need abortion.

FC.15

Interpregnancy intervals less than 12 months: advice given, contraception used and notions of ideal timing

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Objectives The time between one pregnancy and the conception of the next is the interpregnancy interval (IPI). Short intervals of less than 6 months are consistently found to be associated with a range of adverse maternal and neonatal outcomes including maternal anaemia, preterm birth and low birthweight and those less 12 months increase the risk of neonatal morbidity. Amongst women attending two maternity hospitals in Sydney Australia, we sought a random sample of women to examine the timing of their IPIs and their understanding about the optimal space between pregnancies. Methods A prospective questionnaire-based study was performed at two hospitals in Sydney, Australia between Sep 2016 and May 2017. We collected demographic data, previous obstetric history, interpregnancy interval, contraceptive use and perspectives on advice and timing of the current pregnancy and ideal birth spacing from consenting women attending their second antenatal visit or immediately postnatal. Results 316 women completed questionnaires of whom 195 women were pregnant following a live birth. Of these, 119 (61%) reported that neither the hospital nor their GP had provided advice about ideal IPIs, 46.2% had not used contraception between pregnancies and 38 (19.5%) had an IPI 12 months, significantly fewer women with an IPI of < 1 2 months had used contraception after the last birth (21.6% versus 59.9%; p < 0 .001) and significantly more believed that < 1 2 months was an ideal birth interval (73.9 versus 44.5%; p=0.031). Conclusion: Most women who completed a questionnaire following a live birth reported a lack of health provider information about ideal IPIs. Where optimal IPI was understood to be less than a year, women were more likely to have a short interval between pregnancies. Almost half of women did not use any contraception.

FC.16

Using client information systems to examine post-abortion family planning uptake: insights from Marie Stopes centres in Kenya

Claudia Rank, Marie Stopes International, United Kingdom; Laila Gardezi, Marie Stopes Kenya, Kenya; Daisy Adalla, Marie Stopes Kenya, Kenya; Ziporah Mugwanga, Marie Stopes Kenya, Kenya; Katharine Footman, Marie Stopes International, United Kingdom

After accessing safe abortion and post-abortion care (SA/PAC), clients often have an unmet need for family planning. We used routine programme data to assess post-abortion family planning (PAFP) uptake and PAFP contraceptive methods in Kenya.
Methods: We analysed routine programme data for women who visited Marie Stopes centres for SA/PAC services in Kenya from 1 Jan 2015 to 31 Oct 2017. The proportion of women who chose PAFP (contraception on same day or within 14 days of SA/PAC) and uptake of contraceptive methods were examined by type of SA/PAC service (medical or surgical). Data were analysed in Stata version 11, using chi-square tests to assess differences in proportions.
Results: Over the study period there were 46,531 SA/PAC services (26,084 medical and 20,447 surgical). The proportion medical SA/PAC increased from 43.8% in 2015 to 64.5% in 2017. Almost two-thirds of clients were single (65.0%) and their age distribution was: <15 years (0.3%), 15-19 (8.9%), 20 -24 (31.4%), 25 – 34 (45.8%), ≥35 years (13.6%). Overall, 26,928 clients (59.8%) chose PAFP; this increased from 50.7% in 2015 to 66.5% in 2017; $p<0.0001$. PAFP uptake did not vary by age, but was greater among women who had surgical vs medical SA/PAC (71.8% and 63.5% in 2017, respectively; $p<0.0001$). Surgical SA/PAC clients were more likely to choose long acting or permanent methods (76.5% vs 64.2% among medical clients), with a greater proportion choosing intrauterine devices (37.3% vs 13.1% for medical clients).
Conclusions: PAFP uptake was consistently greater among women who had surgical SA/PAC, and uptake of long acting methods was higher among surgical SA/PAC clients. Women may prefer to complete the SA/PAC process before choosing a PAFP method, which may explain lower PAFP uptake among medical SA/PAC clients. Client-centred interventions are essential to ensure women receive family planning methods appropriate to their needs and preferences.

FC.17

Increasing access to Abortion Care Services in the Western Cape, South Africa: The impact of Values Clarification Workshops

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Objectives: Major barriers in accessing abortion services for women include provider opposition, stigma associated with abortion, poor knowledge of abortion legislation, lack of trained providers, and lack of fully equipped facilities. Many providers display negative and judgemental attitudes towards women, with reports of attempts to dissuade women from undergoing an abortion. The Leading Safe Choices (LSC) programme trains and mentors mid-level HCPs in comprehensive abortion care (CAC) with a focus on surgical abortion. However, recruitment of participants for CAC training proved challenging.
Methods: Values Clarification Workshops (VCWs) were conducted with multidisciplinary HCPs and facility managers.

The objectives of the VCWs included exploring assumptions, myths and realities about unwanted pregnancy; providing accurate legal information about abortion; and understanding the difference between personal views and professional responsibilities. Between March 2017 and March 2018, 18 VCWs were conducted with 272 participants.
Results: Uptake of CAC training increased with the introduction of VCWs. In the 15 months prior to the introduction of VCWs (December 2015 to February 2017), 35 providers attended CAC training with 5 being signed off as competent to provide services. In the 12 months following the introduction of VCWs (March 2017 – March 2018) the number of CAC trainees increased to a total of 81 with 19 being signed off as competent after receiving mentorship at their facilities. Since the introduction of VCWs, 11 new CAC sites have been established in the Western Cape. We suggest that VCWs have contributed to this.
Conclusion: Increased uptake of CAC training suggests VCWs have led to improvements in the provision of, and access to, abortion care services. VCWs should be conducted with multidisciplinary teams including facility managers and attendance at VCWs should be a pre-requisite for undertaking CAC training to enable health care providers to offer holistic, respectful and woman centred abortion care.

FC.18

Delivery of audiovisual information on early medical abortion to women in Europe via digital technology: is it acceptable and informative? A multi country study.

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Introduction: Increasing proportions of womenwho access abortion services in Europe choose to have an early medical abortion (EMA) (<= 9 weeks). Provision of quality information on EMA(medications, process, confirmation of success of the procedure and signs/symptoms after the procedurethatnecessitate medical review) is important. However, the quality of information provided to women on EMA may be variable and provider dependent. There is some evidence that audiovisual information (e.g. film or animation) can be an effective way of providing information about abortion. Objective To evaluate an audiovisual animation as a method of information provision on EMA for women seeking EMA in four European countries.
Method: We developed a short animation (3 mins) about EMA that summarises the key steps in theEMA process but is also adapted to reflect subtle differences in EMA practice and law in Scotland, France, Portugal and Sweden. Fifty women choosing EMA in each country (total 200 participants)will be randomisedto information provision on EMA delivered by the animation(n=35) versus a face-to-face consultation with a provider (n=15). Outcomes include information recall on EMA and womens acceptability of provision of information on EMA by the animation.
Results: The study is ongoing. Preliminary data (one country) indicate high levels of acceptability and utility of the animation and comparable levels of information recall to face to face consultations. Free text responses from women indicate that they feel positive about the diversity of female characters depicted in the animation.
Conclusion: Provisional data suggests that even a short audiovisual animation might adequately and acceptably deliver key information about EMA. If shown to be acceptable in the other countries, then this intervention could be used routinely to provide standardised and high quality information to women seeking EMA throughout Europe.

CS13

FC.19

Long-acting reversible contraceptive methods provided for free in a population and the risk of unintended pregnancy

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Objective: To study the effect of a public program providing long-acting reversible contraceptive (LARC) methods at no-cost on the risk of unintended pregnancy.
Methods: The City of Vantaa in the Helsinki metropolitan area (approximately 220,000 inhabitants) implemented a program entitling all women their first LARC method at no-cost in January 2013. During 20132014, altogether 9,685 women entitled to a no-cost LARC visited a public family planning clinic and 2,035 women initiated a no-cost LARC. Lacking data on intendedness of pregnancies, we used induced abortion as a proxy for unintended pregnancy. In this register based cohort study, we used Poisson regression to estimate the risk of abortion among women who chose a LARC method (no-cost group) and among women who visited the clinics, were entitled to a LARC but chose otherwise (visitor group), and in an age matched population cohort (1:4) consisting of non-sterilized women entitled to LARC method (n=36,399). The follow-up started on the date of LARC initiation (no-cost group), date of visit (visitor group) or at start of follow-up for the population controls. Follow-up ended at start of gestation, date of sterilization or move abroad, or on 31.5.2016.
Results: In the full model we adjusted for age, age2, previous pregnancies and abortions, and socioeconomic status. The Incidence Risk Ratio for abortion among women initiating no-cost LARC was 0.27 (95%CI 0.170.39) compared to the matched population control. The abortion rate among visitors did not differ from the population controls (IRR 1.09, CIs 0.951.25).
Conclusions: Among women seeking counseling on contraception, initiation of a LARC method is associated with a significantly lower need of subsequent abortion.

FC.20

Uptake of medical abortion training since approval of Mifepristone in Canada

Dustin Costescu, McMaster University, Canada

Introduction: In 2015, mifepristone was approved in Canada, making it the 61st country to do so. Prior to mifepristone, there were only 60 physicians providing medical abortion in Canada. In anticipation of the commercial availability of mifepristone in 2017, clinicians prepared clinical practice guidelines and an online medical abortion training course. Health Canada mandated training prior to prescribing or dispensing mifepristone, however, in late 2017, the regulation was relaxed from “mandatory” to “recommended”.
Methods: We present participant data on the first 16 months of medical abortion training to provide an estimate of clinicians who are currently eligible and/or likely to provide mifepristone medical abortion across Canada.
Results: Overall, 167 Obstetrician/Gynaecologists, and 408 Family Physicians (which make up the majority of abortion providers in Canada) have completed the Medical Abortion Training Course. 1346 pharmacists have completed the course and are eligible to dispense

the medication. 173 nurses (of which 112 are nurse practitioners with prescribing privileges), 6 midwives, and 151 medical students and residents also have been trained in medical abortion. There is a physician trained in every province and territory, however there is no pharmacist trained in Nunavut, a northern territory.
Conclusion: There is widespread interest and uptake of mifepristone medical abortion in Canada. Within the first year of availability of mifepristone, over 2000 medical professionals have completed the medical abortion training course. In contrast to pre-mifepristone, where very few physicians provided methotrexate-based medical abortion, there are at least 575 physicians currently eligible to prescribe, and 1346 pharmacists eligible to dispense mifepristone.

FC.21

Exploring associations between stigma, abortion reporting and perceptions of abortion prevalence: Preliminary findings from an ongoing survey in Nigeria

Grace Sheehy, Johns Hopkins Bloomberg School of Public Health, United States; Mridula Shankar, Johns Hopkins Bloomberg School of Public Health, United States; Elizabeth Omoluabi, Centre for Research, Evaluation Resources and Development, Nigeria; Funmilola OlaOlorun, University of Ibadan, Nigeria; Suzanne Bell, Johns Hopkins Bloomberg School of Public Health, United States; Caroline Moreau, Johns Hopkins Bloomberg School of Public Health, United States

In Nigeria, abortion is illegal except to save a woman's life, and data on abortion are limited. Performance, Monitoring and Accountability 2020 (PMA2020), in conjunction with the Centre for Research, Evaluation Resources and Development, are collecting nationally-representative survey data on abortion perceptions, norms and stigma in seven states in Nigeria. This study aims to characterize abortion stigma and its correlates, and assess its relationship to perceptions of abortion in the community and the performance of survey-based abortion estimation techniques.
Using a two-stage cluster design, women aged 15-49 in households are interviewed by resident enumerators using smartphones. Women are asked about a range of reproductive health issues, including their perceptions and experiences around abortion, as well as those of their closest confidantes. Survey administration will be complete in May 2018 with a final sample of approximately 11,000 women. Here we report on preliminary analyses of bivariate associations and estimates of lifetime abortion experience. Multivariate regression analysis will be conducted upon attainment of the final sample.
Overall, approximately 70% of respondents felt that a woman who has an abortion brings shame to her family, and 45% reported abortion as common. A higher percentage of women who perceived abortion as shameful reported it as uncommon compared to women who didn't perceive it as such (47% vs 43%, $p<0.001$). Estimates of reported lifetime prevalence of a likely abortion amongst a woman's closest confidante were lower among women who perceived abortion as stigmatized versus not stigmatized (18% vs 22%, $p<0.05$). We recorded a difference in self-reported lifetime likely abortion prevalence among women who perceived abortion-related stigma versus those who did not (13% vs 17%, $p<0.001$).
Our study incorporates data on stigma, perceptions of abortion prevalence, and two methodologies (self-report and confidante) for abortion estimation, allowing consideration of the empirical associations between stigma and these measures.

FC.22

Quality of care and abortion: Beyond safety

Blair Darney, Oregon Health & Science Univ, United States; Bill Powell, Ipas, United States; Kathryn Andersen, Ipas, United States; Sarah Baum, Ibis Reproductive Health, United States; Kelly Blanchard, Ibis Reproductive Health, United States; Caitlin Gerdts, Ibis Reproductive Health, United States; Dominique Montagu, Metrics for Management, United States; Nirali Chakraborty, Metrics for Management, United States; Nathalie Kapp, Ipas, United States

Objective: The safety of abortion is well established, yet quality abortion care must reflect domains beyond safety. We document quality of care definitions, conceptual frameworks, and measures used in the literature and agency practices to inform ongoing efforts to develop quality metrics for abortion.
Methods: We reviewed the abortion and contraception literature, the broader health services and quality in healthcare literature, and agency definitions and tools for quality measurement. We identified seminal definitions and frameworks as well as criteria for quality measures.
Results: Health care quality is the degree to which services produce desired health outcomes and rely on best available evidence. Key frameworks from the Institute of Medicine (IOM) and World Health Organization (WHO) articulate domains of quality, focused on whether health care is effective, efficient, accessible, acceptable/patient-centered, equitable, and safe. Quality is further classified as technical (appropriate care) and interpersonal (interaction with provider). Evidence exists to guide clinical practice in abortion. However, assessment of the quality of clinical practice remains unstandardized, and very little evidence exists documenting client perceptions of both technical and interpersonal quality. Satisfaction, a common quality measure, is limited: women are nearly universally satisfied when they receive needed care, and global satisfaction does not tell us where or how to intervene to improve quality. A wide variety of measures and indicators have been used in the literature and by implementing agencies, but little evidence exists to link these measures with health or behavioral outcomes.
Conclusions: Quality abortion care includes, but is not limited to, safety. We lack both common terminology and measures to assess abortion services across diverse health system settings, especially in low- and middle-income countries. Such measures would allow us to build evidence about the effectiveness, efficiency, accessibility, patient-centered-ness, equity, and safety of abortion services, and ultimately to improve abortion care for women across the globe.

FC.23

Increase of manual vacuum aspiration in the treatment of incomplete abortions in Malawi

Maria Lisa Odland, Norwegian University of Science and Technology, Norway; Gladys Membe-Gadama, Queen Elizabeth Central Hospital, Malawi; Ursula Kafulafula Kamuzu College of Nursing, Malawi; Elisabeth Darj, Norwegian University of Science and Technology; Norway

Objectives: The overall main objective of this study is to improve post abortion care in Malawi by increasing the use of manual vacuum aspiration (MVA) in the treatment of incomplete abortions. More specifically our aim is to investigate if an intervention of training health personnel could increase the safer and cheaper method of MVA by 15%.

Methods: A prospective cross-sectional assessment of the pre/post use of MVA was performed at three public hospitals in Malawi. Health personnel at these hospitals were trained in MVA using theory and practice in April 2016. Two hospitals served as controls. Ethical approval was obtained from Malawian and Norwegian Ethics Committees.
Results: The intervention was successful with an overall increase of 21.3% in the use of MVA after one year. The control hospitals only had 3.0% increase during the same time period.
Conclusion: Training health personnel in using MVA is an efficient way of increasing a safer and cheaper method of treating incomplete abortions in Malawi. However, other factors, such as equipment, is crucial as well.

FC.24

Safety and acceptability of medical abortion by telemedicine at above nine gestational weeks: a cohort study

Margit Endler, Karolinska Institutet, Sweden; Kristina Gemzell-Danielsson, Karolinska Institute, Sweden; Rebecca Gomperts, Women on Web, Netherlands; Leona Beets, Vrije Universiteit Amsterdam, Netherlands

Background**:** Unsafe abortion causes an estimated 43 000 maternal deaths each year. Telemedicine abortion services today abridge the lack of access to safe abortion in many countries. We aimed to evaluate the safety and acceptability of abortion through telemedicine at above nine gestational weeks (gw).
Methods**:** A retrospective cohort study comparing self-reported adverse outcomes among women in Poland at ≤ and > 9 gw who requested abortion through the telemedical service Women on Web between June 1st and December 31st 2016, confirmed intake and provided follow-up (n=615).
Results**:** Among women ≤ and > 9 gw respectively, 3.3% vs 11.7% went to hospital within 0-1 days of the abortion for complaints related to the procedure (AOR 3.82, 95% CI 1.90-7.69). In a stratified analysis the corresponding rate in the highest gestational age group, 11w0d-14w2d, was 22.5% (AOR 9.20, 95% CI 3.58-23.60). Among women ≤ and > 9 gw respectively, the rate of surgical evacuation post-abortion was 12.5% vs 22.6% (AOR 2.04, 95% CI 1.18-3.32), the rate of overall medical interventions post-abortion was 18.3% vs 29.0% (AOR 1.84, 95% CI 1.13-3.00), the rate of heavy bleeding was 6.8% vs 10.1% (AOR 1.65, 95% CI 0.90-3.04), the rate of low satisfaction was 2.4% vs 1.6% (AOR 0.69, 95% CI 0.14-3.36), the rate of bleeding more than expected was 45.6% vs 57.8% (AOR 1.26, 95% CI 0.78-2.02), and the rate of pain more than expected was 35.6% vs 38.8% (AOR 1.11, 95% CI 0.71-1.71).
Interpretation**:** Medical abortion through telemedicine above nine gw is associated with a higher rate of hospital visits for complaints in the days following the abortion compared to abortion at or below nine gw but not with a higher risk of heavy bleeding. It is associated with an increased risk of post-abortion treatment and intervention but not with a lower rate of satisfaction or met expectations.

FC.25

Early medical abortion at home: demographic characteristics which predict preference for home abortion

Lucy Michie, Sandyford Sexual Health, United Kingdom; Audrey Brown, Sandyford Sexual Health, United Kingdom

Objectives**:** In October 2017, The Scottish Government approved a patient's place of residence as a place where treatment for abortion can occur. Women up to 9+6 weeks gestation, can be administered mifepristone in a medical facility and given misoprostol to take home and self-administer 24-48 hours later. The option of early medical abortion at home (EMAH) has been available in our service since April 2018. Following ultrasound assessment of gestation, women who are under 9 weeks are offered the options of EMAH, medical abortion in hospital or surgical abortion. We aim to identify any demographic characteristics which may determine if a woman is more likely to choose EMAH, as opposed to hospital management.
Methods: A prospective review of the records of all women who attend over 4 months from April to July, who are 9 weeks or less and choose medical abortion. To be eligible for EMAH they must live in Scotland, be 16 years or over, have an adult with them on the day of abortion, not require an interpreter and have no significant medical conditions. We will analyse demographic data for those who choose EMAH and those who have medical abortion in hospital.
Results**:** In the first four weeks of offering EMAH to eligible patients, 184 women have been less than 9 weeks gestation and chosen medical abortion. 92 of them were booked to have medical abortion in hospital, and 92 EMAH. Upon completion of data analysis for the first 4 months, we will present the proportion of women who wished medical abortion that were eligible for EMAH, the proportion who chose EMAH and any demographic differences that exist between those choosing home and hospital management.
Conclusions**:** We will determine if any demographic differences exist between women who opt for home or hospital management of medical abortion.

FC.26

Conscientious commitment: Expanding provision to safe abortion by empowering local activists

Joyce Arthur, Abortion Rights Coalition of Canada, Canada

Much attention is given to the alleged right of healthcare professionals to refuse treatment under the guise of "conscientious objection," especially abortion. But what about those who conscientiously commit to providing this life-saving care despite stigma, obstacles, and legal risks? The organization Women Help Women believes in the ethical value of conscientious commitment to provide abortion care as a way to break the taboo around provision regardless of legal settings. WHW does this by equipping local activists and health workers to guide women through self-managed abortion in countries where abortion is illegal.
This presentation will share aspects of WHW's unique partnership model, which is based on collaborative, participatory, feminist efforts to advance access and knowledge. WHW works horizontally, promotes local ownership of joint initiatives, and strengthens and develops capacities of local and regional movements. One example is WHW's "Mobilizing Activists for Medical Abortion" network (MAMA), which operates in at least eight African countries.

MAMA expands community access to information and provides reproductive health training about misoprostol use and self-induction. In 2017, MAMA member organizations reached over 19,000 women with information and services.
In Latin America, WHW collaborates with activists throughout the region, with a focus on Central America, Brazil, and Chile. The group helps local collectives launch and maintain new safe abortion hotlines, trains activists in counseling skills and medical abortion, and supports access to safe abortion via locally-led campaigns and awareness actions. For example, in Chile, the “Misoprostol for All” campaign used radio spots and street actions to promote information about the local safe abortion hotline and the use of misoprostol.

FC.27

Internal and external obstacles to comprehensive abortion services in humanitarian settings: A study on health care providers’ perceptions and experiences

Sarah Fried, Karolinska Institute, Sweden; Elin Larsson, Karolinska Institute, Sweden; Marie Klingberg-Allvin, Karolinska Institutet, Sweden; Amanda Cleeve, Karolinska Institute, Sweden; Kristina Gemzell-Danielsson, Karolinska Institute, Sweden

Objective: About 26 million women refugees worldwide are affected by emergencies and face multiple sexual and reproductive health and rights (SRHR) risks, requiring access to key services. Women in humanitarian emergency settings face increased exposure to unintended pregnancies while lacking access to SRHR services, including safe abortion. An overall growth in institutional capacity in SRHR in humanitarian settings has been reported, however with an exception for abortion-related services. Suggested reasons for this are legal uncertainties, health care providers’ personal moral/attitudes, and lack of quality commodities. However, research confirming or rejecting these hypotheses is lacking.
The aim of this study was to gain a better understanding of health care providers’ readiness to provide safe abortion services in humanitarian settings, and to identify obstacles and facilitators in service provision.
Methods: Ten individual in-depth interviews were conducted with health care providers with experience in working in humanitarian settings in Nepal and Pakistan. An inductive qualitative approach was used for analysis.
Preliminary results: Induced abortion is rarely prioritized or discussed in medical training. Health care providers are willing to provide safe abortions, but often have inadequate knowledge, poor access to updated guidelines, and lack equipment and supplies. Despite being legal, access to abortion is limited. Stigma surrounding abortions consist a barrier both for patients and health care providers, since abortion services often are frowned upon by surrounding communities. Health care providers’ personal values, and involvement of influential people, such as religious leaders, were mentioned as both barriers and facilitating factors.
Conclusions: Further training addressing caregivers’ knowledge, attitudes and values is needed. Information on local legal situations, support to health care providers, in-service training and updated guidelines are lacking. As research on this topic is scarce, this study is of high importance for humanitarian actors with mandate and aim to provide safe abortion services.

Poster presentations

After an abortion

P.001

Decision making preceding induced abortion: a qualitative study of women's experiences in Kisumu, Kenya

Ulrika Rehnström Loi, Karolinska Institutet, Sweden; Matilda Lindgren, Karolinska Institutet, Sweden; Elisabeth Faxelid, Karolinska Institutet, Sweden; Marie Klingberg-Allvin, Karolinska Institutet, Sweden

Background: Globally, about 25 million unsafe abortions take place every year. In countries where restrictive abortion laws are common, safe abortion care is not always accessible to women in need. In Kenya, the high rate of unintended pregnancy resulting in unsafe abortions is a serious public health issue. Gaps exist in knowledge regarding women's decision-making process in relation to induced abortion in Kenya. The objective of this study was to explore women´s experience of decision-making preceding induced abortion when confronted with an unintended pregnancy in Kisumu, Kenya.
Methods: Individual, face-to-face in-depth interviews were conducted with nine women 19-32 years old. Women who experienced induced abortion were recruited after receiving post-abortion care at the Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH) and Kisumu East District Hospital (KDH) in Kisumu, Kenya. In total, 15 in-depth interviews using open-ended questions and a non-judgmental approach were conducted. All interviews were tape-recorded, transcribed and coded manually into categories using inductive content analysis.
Results: This study shows that the main reasons for induced abortion were socio-economic distress and lack of support by the male partner. In addition, deviance from family- and gender-based norms highly influenced abortion decision-making among the interviewed women. The principal decision maker was the male partner who pressed the woman to terminate the pregnancy indirectly through rejection of financial or social responsibilities or directly by commanding her to terminate the pregnancy. In some cases, the male partner mastered her decision to continue the pregnancy by arranging an unsafe abortion without her consent. Strategic choices regarding whom to confide in were employed as a protection against abortion stigma. This contributed to a culture of silence around abortion and unwanted pregnancy, a fact that made women more vulnerable to complications.
Conclusions: The findings suggest that financial, social and gender-based dependencies influence women's agency and perceived options in abortion decision-making.

P.002

Sexual function and background who had induced abortion

Tomoko Saotome, Louis Pasteur Center for Medical Research, Japan

Objectives: For women, it is by chance to experience unwanted pregnancy, but the experience will affect their life styles and sexualities. In our country,contraceptive rate is about 42% of reproductive aged women, and the methods of contraception are limited, so they are mainly using male condom, few women choose oral contraceptives and IUS/IUD, or tubal ligation.

Methods:We asked the women who had induced abortion that the reson of pregnancy, reason of choosing abortion,self-esteem, and what was lacking their situation to continue pregnancy.Usin FSFI(Female Sexual Function Index)questionnaires, we evaluated sexual function just after having abortion and three month later.
Results:About half of women didi not use any contraceptivs, and about half were married women ,their sexual function were decresed after three month from abortion.
Conclusions: Much more information abour methods of contraception they use and care with stand closer with them would needed.

P.003

Quality management of private clinics in Kenya: expanding access to post-abortion family planning

Katharine Footman, Marie Stopes International, United Kingdom; Susy Wendot, Marie Stopes Kenya, Kenya; Edward Ikiugu, Marie Stopes Kenya, Kenya; Rachel Scott, London School of Hygiene and Tropical Medicine, United Kingdom; Inviolata Nafula, UCSF Global Programs, Kenya; Ziporah Mugwanga, Marie Stopes Kenya, Kenya

Objectives: Integration of family planning counselling and method provision into safe abortion services is a key component of quality abortion care. This study aimed to evaluate the effect of a quality management intervention on post-abortion family planning (PAFP) uptake among private socially franchised providers in Western Kenya. The quality management intervention comprised a one-day refresher orientation on PAFP, a counselling job-aide, and enhanced monthly supervision visits.
Methods: We conducted a pre- and post-intervention study between November 2015 and July 2016 in nine private clinics. We conducted a baseline and post-intervention survey among clients of social franchise providers, using in-person interviews on the day of their procedure, and follow-up telephone interviews 14 days later. The primary outcome was the proportion of clients receiving any method of PAFP (excluding condoms) within 14 days of obtaining an abortion. We used chi-squared tests and multivariate logistic regression to determine whether there were significant differences between baseline and post-intervention, adjusting for potential confounding factors and clustering at the clinic level.
Results: Interviews were completed with 400 women at baseline and with 369 women post-intervention. Same-day PAFP uptake was higher post-intervention (19.3% vs 30.8%), as was same-day LARC uptake (12.6% vs 19.5%). After adjusting for clustering and potential confounding factors, the intervention had a significant effect on same-day PAFP (aOR 1.94, $p < 0.001$) and same-day LARC uptake (aOR 1.72, $p < 0.001$). There was no significant difference in PAFP or LARC uptake within 14 days. Clients' reports of quality of counselling and satisfaction with services increased post-intervention.
Conclusions: The intervention may have supported providers to improve their counselling, and helped women choose a contraceptive method on the day of their abortion. However, uptake at 2 weeks did not change, and measures to support women to access contraception after leaving the clinic may be needed.

P.004

A behavioral approach to increase long-acting contraception uptake among post-abortion clients in Nepal: Evidence from an experimental Design

Sabitri Sapkota, Marie Stopes International, Nepal; Pragya Gartoulla, Sunaulo Parivar Nepal, Nepal; Karina Lorenzana, Ideas42, United States; Saugato Datta, Ideas42, United States; Hannah Spring, Ideas42, United States; Jeremy Barofsky, Ideas42, United States

Objectives: Over half of women receiving abortions in Nepal want to delay their next pregnancy by at least two years, but few leave health clinics with a contraceptive method post-abortion. Long acting reversible contraceptives (LARCs) are an effective way to extend gaps between pregnancies, yet uptake at Sunaulo Parivar Nepal (SPN), an implementing partner of Marie Stopes International was low (26%). Appropriate post-abortion family planning (PAFP) counseling by providers is a key determinant of a woman's choice to take up LARC. While providers are intrinsically motivated to help clients, they do not consistently offer PAFP counseling because they tunnel on their primary roles as abortion providers, and have no benchmark for their performance administering PAFP methods relative to peers. Therefore we designed and evaluated the effectiveness of a clinic peer-performance comparison intervention on uptake of LARC among post abortion clients.
Methods: We conducted a provider-level, stepped-wedge randomized controlled trial. We randomly assigned clinics to receive the intervention at one-month intervals from July 2016 to January 2017 (sample size, n=17,149 safe abortion clients). Participating clinics received a poster each month prominently displaying the clinic's LARC uptake rate among post abortion clients. Changing monthly, these rates were contextualized as either 'high' or 'low' or `lowest' relative to other clinics with similar characteristics. Data were collected through existing medical records.
Results: The intervention increased LARC uptake by 6.96 percentage points [95% CI: 1.3 to 12.7, p-value ound that this behavior change occurs by clients switching from short-acting to long-acting methods, instead of increasing LARC rates by reducing the proportion of clients receiving no contraceptive method.
Conclusion: The study suggests that giving SRH service providers timely and salient feedback on their performance relative to their peers is an effective way to improve provision of PAFP.

P.005

A retrospective study looking at the number of women pregnant in the 12 months before an unwanted pregnancy

Bronagh Donaghy, Cardiff University Medical School, United Kingdom; Caroline Scherf, Royal College of Obstetrics and Gynaecology, United Kingdom

Introduction: Unplanned conception after a previous pregnancy is a common occurrence. Women are in contact with services at the time of a pregnancy but little or no thought is spent on how they might prevent the next one. This study aims to determine the frequency of this situation in Cardiff. It reviewed how many women requesting therapeutic abortion, had a pregnancy within the previous 12 months.
Methods: Pregnancy Advisory Service (PAS) attendances at UHW Cardiff, for February 2018 were collected using the patient management system (PMS).

Clinical records were reviewed to identify those with a short pregnancy interval (IPI), which we defined as a pregnancy within the previous 12 months.
Results: Of 129 women, 29 (22.6 %) had been pregnant in the previous 12 months (15 live births, 14 therapeutic abortions) and thus had a short IPI. 99 of the 128 (77%) women had not been pregnant in the previous 12 months or were nulliparous. Contraceptive behaviour was also analysed. Among the women with a short IPI, 14 were using non-LARC methods of contraception at the time of conception of the index pregnancy (IP) and 15 were using no form of contraception.
Conclusion: One in four women requesting abortion had been pregnant and thus in contact with services during the preceding 12 months. This highlights a missed opportunity in providing suitable post-partum and post-abortion contraception. Despite intrauterine contraception (IUC) being the most effective method to lower the risk of unintended pregnancies (UPs), both groups A and B, on discharge, had a higher uptake of non-LARCs compared to LARCs by over 50%.

Conscientious Objection

P.006

Victims of "Conscientious Objection" to abortion: Cases of death and serious injury show that CO is wrong in healthcare

Joyce Arthur, Abortion Rights Coalition of Canada, Canada

Almost 50 women around the world have suffered serous injustice, injury, or death due to the exercise of so-called "conscientious objection" (CO) to legal abortion, according to a website that documents their stories. Most of the cases occurred in Catholic-dominated countries or Catholic hospitals in the USA. But these cases are just the ones that made it to the media or the courtroom, so they are likely the tip of the iceberg. What is the real toll of CO on women? Unfortunately, little is known about how women themselves are affected by the exercise of CO. Despite the large literature on the topic, most of it deals with legal, ethical, and philosophical issues. Debates rage about how to balance the rights of patients with doctors, and how best to regulate CO. Examples of CO regulations are often described or praised, but rarely do we hear if those laws or policies are being followed or enforced, and what actually happens to women on the ground. The victims of CO are too often invisible.
This presentation will showcase several examples of women who died or were left seriously injured as a direct result of the exercise of CO against abortion. These extreme cases help illustrate the unethical and dangerous nature of CO. It will be argued that harm to patients occurs on a continuum and is an inherent aspect of CO. In fact, so-called "conscientious objection" is more accurately called "Dishonourable Disobedience." It is inappropriate in healthcare and should be eliminated.

Contraception

P.007

Impact of the contraceptive implant on maternal and neonatal morbidity and mortality in a rural community in Papua New Guinea

Sarika Gupta, University of Sydney, Australia; Kirsten Black, University of Sydney, Australia; Glen Mola, University of PNG; Papua New Guinea, Philippa Ramsay, University of Sydney,

Australia; Kevin McGeechan, University of Sydney, Australia; Kate Cheney, University of Sydney, Australia

Background: Effective contraception lowers maternal morbidity and mortality by limiting exposure to unintended pregnancy and unsafe abortion. Levonorgesterel implants have been available in Papua New Guinea (PNG) since 2013, but their impact on maternal health has not been studied. We assessed the impact of the implant on maternal and neonatal morbidity and mortality within a rural population on Karkar Island, Madang province in PNG.
Method: We conducted a retrospective observational cohort study to compare the rates of severe haemorrhage, postpartum infection, hospital readmission, prematurity (< 3 7 weeks), low birth weight (< 2 500g), maternal and neonatal mortality before (2010—2012) and after (2014—2016) introduction of the contraceptive implant. We also analysed any changes in crude birth rate (CBR) and in the number of pregnancies affected by grand multiparity (≥4) and short inter-pregnancy interval (< 1 2 months). Data was extracted for 3651 births occurring between 2010—2016 and analysed using interrupted time series and Poisson regression.
Findings: Findings: Following introduction of the implant the rate of selected adverse birth outcomes decreased by 63 to 88% ($p < 0.0001$), the number of women birthing with parity ≥4 reduced by 59% and with inter-pregnancy interval < 1 2 months by 80% ($p < 0.0001$). CBR was stable until 2012 then significantly declined from 2014 ($p < 0.0001$).
Interpretation: We provide evidence that the introduction of the contraceptive implant was associated with significant reductions in maternal and neonatal morbidity and in the number of high- risk women birthing.

P.008

To examine the failure rate and Disruptions of contraceptive use by different spacing methods of family planning in four selected states of India

Rohit Singh, National Health Mission, India

The paper attempts to examine the failure and abandonment by different spacing methods of family planning and to know the reasons behind contraceptive failure and abandonment by method. We tested the hypothesis- Women from poor economic status tend to have higher relative risk for abandonment and Women having health related reasons more likely to discontinue family planning method. The data for the present study is taken from the third round of National Family Health Survey (NFHS-4) conducted during 2015-16 Cox-regression model has been used to analyze calendar data. The study shows that mainly fertility and health related reasons were the reasons behind discontinue for the last method. Method related reason was also having its significance in abandonment of the last method in all the selected states. Pearl pregnancy index was generally lower for five years exposure period as compare to three years exposure. In all the cases, those women who had desire for additional child have higher relative risk to discontinue the method.
The study suggests that programmes should have fair provisions on inter personal communication and counselling on the efficacy and possible side effects of any contraceptive method before providing the method.

P.009

The comparative risks allied with the start of different contraceptive use in India and its most populous states Uttar Pradesh

Rohit Singh, National Health Mission, India

Objective/Hypothesis: The paper attempts to examine the timing of initiation of contraceptive use at first time and after recent childbirth among currently married women and the relative risk associated with initiation of contraceptive use by socio-economic and demographic characteristics. We tested the hypothesis-whether women who do not want any additional child initiate the contraceptive use early.
Data: The three rounds of the National Family Health Survey (NFHS), 1992-2015 have been used to reach the first objective. To meet the second objective, the calendar data provided in NFHS-4 have been used. The calendar data provide information on reproductive history during six years preceding the survey date. Due to recall lapse we have considered the events only during three years preceding the survey.
Methods: Cross-tabulation and Cox Regression Hazard Models Findings: The study reveals that a larger proportion of younger women start using a method without having any child. More than three-fourths women (15-19) begin to use family planning method with less than two surviving children, whereas most of the older women wait until they had at least two surviving children. Interestingly, for illiterate women the acceptance of family planning at 3+ living children as first use has gone up from 38 to 43 percent during 1992 to 2015. However, it is high among younger women. Prevalence of limiting method users is increasing over the period and most of the women have gone for sterilization in same month of last birth (i.e. around 35 percent) in India. The multivariate analysis suggests that programme variables like ANC and place of delivery (institution) affects the relative risk to initiate the use of contraceptive method after child birth.

P.010

« Direct method » for IUD and LNG-IUD insertion: efficacy on insertional pain reduction and 6-month tolerance: a prospective comparative study

Aurore Bastin, Médecin généraliste, France; Alexandre Scanff, CHU Rennes, France; Samah Chaaban, La Case de Santé, France

Objectives: Intrauterine devices (IUD) and levonorgestrel-releasing intrauterine devices (LNG-IUD) are efficient contraceptive methods with low side-effect rates. However, apprehension of insertional pain often prevents women from choosing them as first-line contraception. Therefore a new insertional method was invented in 2005 in France in order to reduce the pain experience during IUD placement. The aim of this study was to compare the pain experienced during IUD placement between this new insertional technique: the “direct method”, and the conventional insertional technique, and to observe complications and user satisfaction over 6 months.
Methods: This prospective open-label study included 535 women between June 15 and December 15, 2016 in France.
Women were recruited by general practitioners, gynecologists and midwives using either the direct method or the standard method. 281 were included in the direct-method group and 254 in the standard-method group.
Results: Women in the direct-method group reported less intense pain than women in the standard-method group ($p < 0.001$). This result was confirmed by multilevel multivariate analysis (-8.3/100 IC95%(-14.3to-2.3)). The number of previous vaginal deliveries, a history of vaginal or cesarean delivery in the preceding 3 months, and a very soothing consultation atmosphere contributed to reduce pain, whereas a history of previous placement failure, a high-level anticipated pain, and the use of a tenaculum were associated with an increasing pain level. There was no difference between the two groups regarding occurrence of complications, 6-month IUD presence rate, and 6-month IUD satisfaction rate.

Conclusions: The direct method for IUD insertion appears less painful, without increasing the risk of complications. It could be preferable especially for women most at risk to experience severe pain: nulliparous women and women with no previous vaginal delivery.

P.011

Unmet needs in contraception during the post-partum period, how to be more efficient?

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The period following the birth of a child is a period of « contraceptive vulnerability ».
Statistics from the canton of Vaud (CH) show for the past 10 years a high rate of termination of pregnancy occurring within two years after childbirth. At the CHUV, the topics fertility and contraception are traditionally discussed during the postpartum (PP). However, given to shortened duration, women are not always available and have other priorities. In 2008, the CSS-PF therefore also initiated an outpatient consultation at 6 weeks PP for women who did not benefit from specific information when at the hospital. Analysis revealed high unmet need.
Hypothesis: Address contraception during the short stay in hospital does not seem sufficient to ensure optimal contraceptive choice. An additional offer of counseling further upstream seemed to be essential.
Material & Method: Since June 2017, the CSS-PF thus completed its offer by proposing a new antenatal consultation between 25 and 35 weeks of pregnancy. The semi-structured interview was documented and analysed.
Results: According to the first feedback gathered at the end of the consultation, women seem to appreciate to discuss these topics during their pregnancy. The anticipation of future needs seems to increase the awareness of the need for contraception starting from the postpartum period. This seems particularly true for women who have had an unplanned pregnancy. Final results will appear at the time of presentation.
Conclusion: The antenatal consultation is a good time to address fertility in order to anticipate postpartum contraceptive choice. Women and couples say they appreciate this time dedicated to reflection and discussion about sexual health matters during pregnancy.

P.012

Non-attendance for post-TOP intrauterine contraception; what causes it and can we improve rates?

Rosemary Cochrane, NHS Lothian, United Kingdom; Hannah Pulford, University of Edinburgh, United Kingdom

Background: Increased uptake of LARC methods post-TOP could help to reduce further unintended pregnancy. Delaying insertion of an intrauterine device (IUD) after abortion has been shown to be a barrier to uptake and there is evidence that efforts to increase the uptake of effective methods of contraception can be effective.
Aim: This project aimed to determine and evaluate the factors affecting the attendance at our “fast-track” post TOP IUD appointment, and thus subsequent uptake of intrauterine contraception following termination. We wished to ascertain if any of these factors could be influenced to improve attendance.

Methodology: A retrospective database review of 300 women who had attended the "Choices" TOP service at Chalmers Sexual Health Centre and had an IUD appointment thereafter at three discrete time periods between 5/2/16 – 25/1/18, was audited, using medical electronic records (NaSH). The different time periods related to the completion of transfer of services from secondary care into community sexual and reproductive healthcare Data collected was: time between TOP and IUD appointment, age, previous TOP, site of TOP counselling, site of TOP procedure and evening or daytime timing of the appointment. All variables were statistically analysed using SPSS with regards to attendance at the IUD appointment.
Results: Overall attendance was 53%. Average time from procedure to appointment was 26 days and did not differ between attenders and non-attenders. Evening appointments significantly increased attendance (62% evening v 49% daytime, $p<0.05$). There was no statistical significance within the other variables.
Conclusions: Attendance remains poor, despite all contraceptive counselling being delivered by sexual health professionals and efforts to decrease procedure-appointment intervals; we plan to continue these efforts. We need to consider patient convenience for appointment timing, and plan to introduce opt-in Contraceptive Choice evening sessions.

P.013

Understanding nexus between abortion services uptake and family planning profile of young women

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Introduction and objective: The unmet need of Family Planning (FP) in Pakistan is 20%, modern CPR is 26%, wanted fertility rate is 2.9 compare to total fertility rate of 3.8, 66% of married women never visited providers for FP services[1], annual abortion rate is 50/1000 women[2], three out of four induced abortions could be eliminated if FP needs were fully met by expanding and improving FP services and choices[3]. Objective of this informative study is to understand nexus between abortion services and FP profile of young women (15-24 years) when attending a clinic for abortion and/or FP services.
Methods: Data is collected from daily client-record register of semi-urban doctor-based NGO clinic in Lahore district.
Data of all young woman seeking abortion and/or FP services between 01July-31Dec, 2017 is extracted from registers. Data management sheet is developed and preliminary descriptive analysis is carried out using SPSS.
Results: A total 243 young women had 281 visits out of which 213 (87.6%) visited only once. During these visits, 235(83.6%) received FP only, 21(7.5%) FP and abortion, and 25(8.9%) received only abortion related services. Out of 24 post-abortion contraceptive clients, 16(66.7%) are never users [uptakes: Pills:15(93.8%), IUCD:1(6.3%)] and 8(33.4%) are ever users [uptakes: Pills:4(50%), IUCD: 4(50%)]. Except 3 abortion clients who have not taken post-abortion contraception, 18(85.7%) induced and 3(14.3%) incomplete abortion clients have taken post-abortion contraception.
Conclusion: Preliminary results demonstrates adequate acceptance of post abortion contraception by young abortion clients out of which substantial number of young women is taking up pills followed by IUCD. Detailed analysis is underway and expected to generate more informative nodes between FP and abortion services.
[1] PDHS, 20012-13

[2] Arif S, Kamran I., Exploring the choices of contraception and abortion among married couples in rural Punjab, Pakistan, Population Council, 2007.
[3] Unsafe abortion incidence and mortality- Global and regional level in 2008 and trends during 1990-2008, Information Sheet, WHO

P.014

Youth AFC: peer contraception

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The goal of the AFC jeunes * (French Association for ContraceptionYouth) is to inform young people by young people (peers) about contraception so that they can achieve a well-being in the love relationship and sexuality. Indeed, we observed that the information to be delivered passes more efficiently when young people speak to young people in festive environments and not within the constrained framework of the school environment in a teacher - taught relationship. For this purpose, Participants during the festivals, have the opportunity to become familiar with contraception by meeting young people trained by the AFC on this subject (peers). Peers walk to meet the festival-goers or receive them at the booth of the AFC inside the festival. They provide information on contraception using a quiz. If necessary, they will provide also them with information on where they can obtain contraception, the prices and resource persons. As festival participants are mixed it is also a rare possibility to inform the boys who rarely visit family planning.
Peers are young volunteers who are interview by AFC officials to know their motivations. They receive initial and continuous training, which provides them with a common framework to which to refer as well as a space for exchanges. A trainer (member voluntary of AFC) is always present physically at the festival to answer any questions.
Trainers and peers are required to adhere to the values of freedom, independence, responsibility and confidentiality. The trainer and peer have a duty of confidentiality regarding any information they hear.
The AFC Jeunes has trained about 150 young people since 2008. They are able to promote contraception in festive places with young people of their age, to be resource persons with the young people of their surroundings and to use these skills for themselves.

P.015

Increasing the uptake of LARC in complex abortion patients at a tertiary teaching hospital

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Background: There is a pressing need to reduce unintended pregnancies and evidence indicates that increasing the uptake of LARC can play a substantial role in addressing this public health issue. Several interventions to increase LARC uptake have been tested.

Effective counselling pre-insertion is the most effective intervention. Methods: We audited high risk women attending the pregnancy advisory clinic to discuss contraceptive options, offer contraception counselling and education regarding the different methods. Seventy case notes audited each year over a period of three years. A pre-designed proforma is used for this continuous audit. Results: The total number of patients audited in this study is 210 patients. The number of patients who have documented evidence of having all methods of contraception discussed is 100% (increased from 97.% and 92.5% in previous years) Our LARC uptake has risen over the three year period and reached a peak of 75.4% uptake (56% and 49% previously). Of this 29.5% nexplanon, 24.6% IUS, 1.6% IUD, 19.7% injectable progesterone. Only 6% requested progesterone only pills or combined hormonal contraception and 13% opted to continue with condoms or declined any contraception. Conclusion: There has been significant improvement in uptake over the three year period. To achieve and maintain this considerable improvement we have consistently disseminated the findings to the nursing and medical staff and after the second round disseminated to theatre staff as many LARCs are fitted after surgical abortion. We developed a checklist for use in clinic and the ward which aids the whole team in ensuring all patient needs are met and all options offered. Education regarding the importance of contraception and the need to commence this by day five has been essential for for both patients and staff as well as dispelling many common myths. We now also offer Nexplanon fitting at time of mifepristone for medical abortions.

P.016

Fishing for the misplaced coil

Ruchira Singh, Birmingham Women's & Children Hospital NHS Trust, United Kingdom; Kate Campbell, Birmingham Women`s & Children Hospital NHS Trust, United Kingdom; Lisa Cavery, Birmingham Women`s & Children Hospital NHS Trust, United Kingdom

Case : A 31 year old nulliparous woman presented with pain and dyschezia 6 weeks post insertion of Cu-IUD. The device was fitted in the community by her general practitioner and the patient reported severe pain at the time of insertion. The pain persisted post-procedure with the patient describing shooting pains into her rectum. Two weeks later she also complained of rectal pressure and faecal urgency.The threads of the Cu-IUD were not visible at the 6 week post insertion check. An ultrasound scan was inconclusive. An abdominal x-ray was then requested and showed the Cu-IUD was in the plane of the uterus.

Due to the patient's severe and persistent symptoms, a diagnostic laparoscopy was arranged. Intra-operatively the coil threads were visible and led to the body of the device buried within adhesions between the sigmoid colon and the posterior wall of the cervix. Cautious dissection was required to release the bowel and remove the Cu-IUD. There was inflammation and pus within the mass. The dissection was further complicated by a single long sigmoid diverticulum that had become adherent to the inflammatory tissue. Conclusion :The exact mechanism by which the Cu-IUD reached this area was unclear as there was no evidence of uterine or cervical perforation. One possible explanation is that the device was inadvertently inserted through the posterior fornix, perforating the vagina in to the recto-vaginal space. The rate of uterine perforation at the time of fitting an intrauterine device is 2 per 1000, however perforation of the vagina is rare and poorly described.

P.017

Long-Acting Reversible Contraceptive methods provided free-of-charge – do the rates of discontinuation within a year after insertion differ?

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Objective: To compare the proportion of different long-acting reversible contraceptive (LARC) methods discontinued within a year after insertion when offered free-of-charge.
Methods: Every woman has been entitled to her first LARC method free-of-charge in the City of Vantaa, Helsinki metropolitan area of Finland since the beginning of 2013. With 220,000 inhabitants, Vantaa has four public family planning clinics that provide comprehensive contraceptive services – including abortion referrals and follow-up. The clinics offer initiation of the various LARC methods provided by the city as well as LARC removals.
We collected information on all 2035 women initiating a LARC method free-of-charge in 2013-2014 from the electronic patient records of the family planning clinics of Vantaa. We also evaluated the records of all these women to identify the LARC removals performed in the health centres or family planning clinics of the city. Information on the possible removals elsewhere was not available. We calculated the risk ratios (RR) and 95% confidence intervals (95%CI) for removals.
Results: Of the altogether 2035 LARCs inserted, 1203 were levonorgestrel intrauterine systems (LNG-IUS). Of those 124 were the 13.5mg LNG-IUS and 1079 the 52mg LNG-IUS. Implants were inserted to 646 women (637 etonogestrel implants and 9 levonorgestrel implants). Copper-IUDs were chosen by 186 women. Of the 52mg LNG-IUSs 132 (12.2%), of the 13,5mg LNG-IUSs 16 (12.9%), of the etonogestrel implants 92 (14,4%), of the LNG-implants 1 (11%) and of the copper-IUDs 40 (21,5%) were removed within a year of insertion. Compared to the 52mg LNG-IUS, the 13,5mg LNG-IUS revealed a RR=1.1 (95% CI 0.7-1.7), implants RR=1.2 (0.9-1.5), copper-IUDs RR=1.8 (1.3-2.4, $p < 0$ .001) of being removed within a year after the insertion.
Conclusions: Compared to 52mg LNG-IUS, copper-IUD had a higher risk of discontinuation within a year of insertion. Implants or 13,5mg LNG-IUS did not statistically differ from 52mg LNG-IUS. These data are important when assessing the overall impact of LARC provision.

P.018

How well do we manage our young persons in contraceptive clinics

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Objective: To assess how well we manage young persons attending our contraceptive clinics.
Methods: A retrospective review of the clinical records of all young persons under the age of 18yrs attending our contraception clinic in Walsall UK, from the 1st of January 2018 to the 31st of January 2018. We assessed if certain criteria[1] regarded as good practice in this population were demonstrated as met in the documentation in the clinical notes. The criteria included reassurance of confidentiality, documentation of competence (Gillick competence/ Fraser Guidelines), discussion and offer of all methods of contraception, discussion on emergency contraception, risk assessment for sexually transmitted infections(STI) and discussion of 'safe sex'.

Results: A total of 50 females attended our contraception clinic in the period under study, 4 clients were aged 18yrs, 7 were 17yrs, 14 were 16yrs, 20 were 15yrs and 5 under 14yrs . The ethnicity showed 45 were white British, 2 were mixed race white/Black Carribean, 1 mixed white British/Black African, while 2 did not have ethnicity documented. 43 clients had a discussion/offer of all methods of contraception documented, 7 did not. 46 clients had it documented that emergency contraception (EC) was discussed but 4 did not. The Nexplanon implant was the most common method chosen by 18 clients, Medroxyprogesterone acetate injection 13, Combined oral contraceptive pills 11, Progestogen-only Pills 5 and Patches by 3 clients. STI risk assessment was performed in all 50 clients but only 12 accepted a test and 38 declined. Condoms were offered to all 50 and accepted by 13 but declined by 37 of the clients. Confidentiality discussed in 23, Emergency contraception in 46(93.2%) and Competency assessed in 26 clients.
Conclusions: The Clinic performed well in STI risk assessment and offering/SafeSex/condoms to all 50(100%) clients. Long acting reversible contraception uptake was good at 31(62%) of the 50 Clients. No one accepted IntraUterine contraception. Competence assessment, confidentiality discussion and access to males and ethnic minorities needs improvement.
Reference: 1. GMC/FSRH/NICE Young Persons Guidance

Counselling

P.019

Updating the evidence: Mental health outcomes and abortion

Angela Dawson, University of Technology Sydney, Australia; Elizabeth Sullivan, Unversity of Technology Sydney, Australia

While a number of systematic reviews have identified that induced abortion for an unplanned pregnancy does not impact upon a women's health limited evidence and weak studies have hampered the delivery of insights to inform health service delivery. The relationship between induced abortion and the mental health of women is complex, as women's responses are also affected by social determinants that depend on context. Interventions such as counselling, behavioural therapies, education and emotional support may be appropriate to improve outcomes for women before and after an abortion. This paper will present the findings of a systematic review we undertook to determine if women who obtain an induced abortion for an unplanned pregnancy are at greater risk of adverse mental health outcomes compared to women who proceed with an unplanned pregnancy and give birth. Included studies comprised a mental health measure at least 90 days following an abortion by clinical diagnosis, validated scales or treatment records. A structured search of the peer reviewed primary research literature since the last review in 2011 was undertaken. Data from the included studies was extracted independently by two reviewers using the standard tool for data extraction as set forth by the Joanna Briggs Institute. Findings will also identify the factors associated with adverse mental health outcomes and interventions that have been delivered to address these.

P.020

Long Acting Reversible Contraception- Effect of a multi-centric study on clinical behaviour of a single centre

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Italian Law 194/78 allows performing abortions only in Public Hospital Centres. Recently AOGOI (Associazione Ostetrici Ginecologi Ospedalieri Italiani) organized a Multi-centric Study on counselling in post-abortion contraception. This study involved our Centre along with other 15 ones all over Italy, during a 12 months period starting from September 2016. All medical and paramedical staff were asked to deliver and collect a booklet to be completed for each patient who accept to participate. Patient had to anonymously write which kind of contraception has done in past and which one she will choose after abortion. Then data have been centralized and analysed and results have already been presented at National Italian Gynaecological Congress (SIGO 2017).
We now want to highlight an unexpected effect of taking part the study.
During study period we performed 1334 dilatation and aspiration (DA) and we have positioned 361 Intra Uterine Device/System reaching a 27% of Long Active Reversible Contraception as never happened before. For example from 2012 to 2016 only 15% of our 6076 patients chose a LARC as post-abortion contraception. The difference is statistically significant (P <0,01).
During past five years our staff, our availability of LARC and our time dedicated to contraceptive counselling were the same. Something has changed in quality. Two preliminary hypotheses. First-one: patients confronted with having to write down their choice, more reflected on contraceptive options. Second-one: the medical and paramedical staff was more motivated in counselling because the data would have been compared with those of other Italian centres. In any case, this AOGOI project, devised to study how to increase adhesion to more effective post-abortion contraceptive choices, has already worked out.

P.021

Effectiveness and acceptability of medical abortion through telemedicine – a randomized controlled non-inferiority trial

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Background: In many countries medical abortion is still not available. For that reason, Women on Web (WOW) was initiated as an interactive website that supports women with counselling and procurement of medical abortion. Previous studies have shown that telemedicine and medial abortion through WOW is safe, acceptable and with outcomes similar to medical abortion provided traditionally following face-to-face counselling (Gomperts et al., 2008, 2011, 2014, Grossman et al.,2011).

Today Swedish women have the option to self-administer misoprostol at home after a face-to-face counselling in the abortion clinic and to evaluate the outcome by self-assessment using a low sensitivity UhCG test (Sunde Oppegaard et al., 2015, Lyengar et al., 2015). This study was conducted to assess the effectiveness and acceptability of medical abortion through telemedicine, home-use of misoprostol and self-assessment of the outcome.
Material and methods: Prospective randomised controlled non-inferiority trial comparing routine face to face counselling with telemedicine counselling (intervention) in women with an unwanted pregnancy, with no contraindication to medical abortion and self-administration of misoprostol at home, up to 63 days of gestation. Primary Outcome: Efficacy (complete abortion without ongoing pregnancy or surgical intervention for incomplete abortion up to 30 days after the abortion treatment). Secondary outcomes; safety, acceptability, surgical interventions, contraceptive uptake and unscheduled contacts.
Sample size: To establish non-inferiority of telemedicine vs. routine counselling within a 3% margin, with a two-sided 95% CI (or a one-sided 97.5% CI) for the difference in efficacy, 90% power, and to compensate for a 10% loss to FU we will include a total of 1508 women.
Results: Counseling through telemedicine is safe and effective for women and health care and will increase access to safe abortion and increase autonomy for women. Women's experiences from using WOW´s telemedicine service will be presented.
Key words: medical abortion, telemedicine counseling, women on web.

P.022

Qualitative experiences of family planning counseling among adolescent mothers in Hamilton, Canada

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Background: Rapid repeat adolescent pregnancy carries with it both medical and social risks. Reasons for rapid repeat pregnancy (RRP) are multifactorial. While LARC methods may reduce the incidence of RRP, this is dependent on women receiving adequate counseling. We sought to understand, in a qualitative manner, enablers and barriers to accessing contraceptive counseling.
Methods: We performed interviews with 10 adolescent young mothers, and 10 maternity care providers (obstetricians, family physicians, and midwives). Data saturation was obtained with this sample size. Coding was performed to identify themes related to the provision of family planning counseling and contraceptive access.
Results: Four themes emerged. 1) Understanding the adolescent experience: teens seek information when it is relevant for them, and this may not follow the typical obstetrical teaching pattern. 2) Building relationships between adolescents and providers: it takes significantly longer to develop a therapeutic and trusting relationship between teens and their care providers. This may be especially true for teens with limited exposure to the healthcare system previously. 3) System limitations: every maternity care provider identified someone else who "should" be doing contraception counseling, and teens did not understand the role of maternity care providers (the "baby's doctor") as contraceptive providers. 4) Defining success: respondents felt that success did not always result in a contraceptive prescription, but conversations were successful when teens were engaged, there was an opportunity to challenge current beliefs, and birth control discussions were initiated early.
Conclusions: Adolescent mothers and their care providers identified the need for ongoing, context-specific conversations about family planning. Adolescent-initiated conversations warrant respect and attention, as these provide an opportunity for trust-building.

Teens and providers broadly defined success as occurring when there was respectful two-way communication, and an opportunity to challenge current beliefs, whether or not contraception was ultimately provided.

P.023

Gynecological topics on a virtual website

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Objective: To investigate the most common health topics researched on a professional health website (https://www.zdravobudi.hr/) by the number of page-views based on the sex and age of the viewer.
Methods: Page views on a health website were analyzed using appropriate software. The total number of page-viewers (100%) was analyzed regarding the preferred health topics based on page opening from January 1 through December 31, 2016.
results: Among page-viewers, 75.6% were female and 24.4% were male. The majority of participants of both genders were between 25-34 years of age (37%); the fewest participants of both genders were ≥65 years of age. Preferred health topics and the number of page-viewers who clicked on the pages included gynecology (9642), psychiatry (6496), cardiology (5206), and others. The most viewed gynecological topics were contraception, unplanned pregnancy, and prevention.
Conclusions: Modern communication techniques, such as websites and social media, influence every aspect of human life. Regarding websites containing health information, it should be emphasized that it is crucial to inform visitors to view only health content authored by health care professionals. Otherwise, so-called “health” advice could be inaccurate, and sometimes may even result in harm. Analysis of the professional health website confirmed that the column that garnered the most interest was the gynecology column, authored by a gynecologist. The content on the website was written in a simple and widely understandable style, with medical titles placed in brackets. Presenting health material in a reader-friendly manner turned out to be the best way to get closer to the population. This study confirms our belief that correct information from medical specialists plays a huge role in education and sensibilization of various populations to various health topics, and the gynecological content authored by a gynecologist is the most-often visited, read, and commented upon.

Education

P.024

The patient has the answer: Online tools for teaching patient-centered pregnancy decision counseling

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Objectives: The WHO Clinical Practice Handbook for Safe Abortion Care requires counseling “using simple language, maintaining privacy, supporting women to ask questions and taking time to give answers, and not imposing our personal values and beliefs.” Yet, abortion providers often lack the training, language, or techniques to guide patients to self-directed decisions.

We address this gap by offering free online resources about patient-centered counseling in pregnancy decision-making and pregnancy termination methods. Our dynamic workshop combines video-based lectures, subtitled in Spanish and French, pregnancy options counseling frameworks, patient decisions aids, small group activities, and readings so learners can acknowledge the potential for a judgmental reaction to interfere with the patient-clinician relationship and develop strategies to minimize bias during patient encounters.
Methods: This workshop integrates lectures from Abortion: Quality Care and Public Health Implications (Abortion Course), the first Massive Open Online Course about abortion, with a new video-based counseling curriculum, Pregnancy Decisions Counseling Framework. The workshop will model flipped classroom approach with simulated patient encounters and small group discussion.
Results: We will present the workshop contents, highlighting the new counseling curriculum, and instruction about how to conduct the workshop. We will present data about use of the online resources. For example, in the last year, the Abortion Course videos were viewed 27,000 times and accessed in 155 countries. Results will include data about the integration of content into accredited training programs and use by NGOs, as well as individual user feedback.
Conclusions: This patient-centered counseling workshop can be used by educators within their existing teaching settings or by self-paced learners who want to improve their skills in patient-centered counseling. By engaging with these learning tools, practitioners can better provide care that is respectful of and responsive to individual patient preferences, needs, and values, and empower people to take charge of their own health.

P.025

Abortion training in Australia: development of advance training modules for trainees of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Kirsten Black, University of Sydney, Australia; Deborah Bateson, Family Planning NSW, Australia; Paddy Moore, The Royal Women's Hospita, Australia; Philip Goldstone, Marie Stopes, Australia

Objectives: Australia Abortion training in Australia remains ad hoc. Surgical abortion is by provided by gynaecologists in a hospital setting or, in the majority of cases, by non-specialist medical practitioners in the private clinic setting – there is no standardised training curriculum and training is 'on the job'. Medical abortion is mainly carried out in private clinics and in some public services. The objective are to describe the program being developed for trainees of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) to strengthen abortion workforce in Australia.
Methods: RANZCOG has developed an abortion advanced training module based on the one developed by the RCOG that aims to provide a framework on which to base expert training in the knowledge, clinical skills and professional attitudes required to provide comprehensive high level abortion services. The ATM has been trialled over a three year period.
Results: The training comprised at least one clinic a week and one operating session a week over a 12 month period and a workplace based assessment in medical and surgical abortion. The four registrars who completed the trial training reported high levels of satisfaction with skill development and knowledge and all have indicated increased comfort in abortion care and intent to continue to practice in the field. The supervising consultant reported that having advanced trainees included in the general gynaecology training /service roster has done much to improve the perception of abortion care as core business within the college training program and elevate the field in line with other special interests.

Conclusion: The training program for RANZCOG trainees in SRH has the potential to not only increase clinical capacity and leadership but to also raise awareness of these areas as a valued area of practice.

P.026

Refugee women/girls and safe abortion

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The main objective of the initiative SRH Serbia has launched in 2017, was to improve SRHR and gender related rights of refugee/migrant women and girls whose staying in Serbia was prolonged due to the closure of the Balkan route, through challenging/changing accepted social/cultural (including religious) and gender norms and stereotypes which have a huge impact on their (in)ability to recognize, accept and realize their rights.
The contraception and abortion attitudes assessment, conducted though focus groups (four focus groups, in total 46 women and girls participated) and deep interviews with refugee girls and women (20 of them, age 18-40), showed that most of women don't think that it is women's right to decide (solely) if/when/how many children to have.
SRH Serbia developed/adapted its sexuality educational program with the focus on contraception and right to abortion with attitude transformative approach towards abortion, contraception and gender related issues.
The program was designed to, through their recognition of all values/assumptions they possess, to challenge them, to reconsider them as culturally produced/dependent and to discover different, rights-based attitudes/values towards abortion and contraception. Various examples of denied rights to safe abortion were included in facilitated discussions.
The evaluation of the program through post-test showed that most of women changed their attitudes towards abortion - almost 70% answered that abortion should be considered as a human/woman right, although only 40% of them expressed that they would have an abortion. Pre-tests showed that only 17% of them would make decision to have an abortion, even if their husband is against it, while at the end, 35% said they would do that.
The program could be considered also because of the increased expressed needs for condoms to SRH Serbia provides, as well as seeking for SRHR related counseling, including pre-abortion, conducted in our Drop in Centre.

P.027

Teaching on abortion at UCL medical school: Helping students to help women

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Background: UCL Medical School utilises a range of methods in abortion teaching in order to present a balanced but woman focused view to students. In previous UK studies 62% and 72.8% of medical students identified as pro-choice.
Objectives: To understand:

- UCL Medical students' opinions on abortion teaching and how personal values shape their experience

- How students' personal beliefs might affect future involvement in abortion care

Methods: A cross-sectional online opinio survey encompassing Likert-scale and free-text data was emailed to Year 6 students in December 2017. UCL Research Ethics Committee (Project ID 415/003) approval.
Results: 146 questionnaires were returned with 101 completed, with 68 female, 27 male, and 1 non-binary participants. Average age was 24 (response rate 41%). 84 students identified as pro-choice, 95% CI (77%-91%), 13 students identified as pro-life. Students were generally satisfied with the amount of teaching, with eight free text comments describing teaching as "excellent". 103/107 rated their abortion teaching as important, with no correlation between students' attitudes and rating of importance of teaching (Spearman's correlation = -0.0, p = 0.7). There was disagreement on whether abortion assessment clinic placements should be opt-in, opt out or compulsory. As attitudes became more 'pro-life', students became less willing to be involved in abortion care ($p < 0.05$ using Spearman's correlation). Students interested in specialties involving abortion care are more likely to be pro-choice - 119 responses, than pro-life - 15 responses. Students would like more role play practice on abortion consultation and more reminder emails about opt-in clinics.
Conclusions: 95% of UCL medical students identify as pro-choice. Both pro-choice and pro-life students rate abortion teaching as important. Students value a range of teaching methods and balance of speakers. Students who identify as pro-life are less interested in specialties involving abortion care and more likely to opt out of abortion care when qualified.

Emergency contraception

P.028

Measuring of knowledge and attitude of Hungarian pharmacist towards emergency contraception pills

Melinda Vanya, University of Szeged, Hungary; Matuz Mária, University of Szeged; Hungary; Ria Benko, University of Szeged, Hungary

Objective: We aimed to conduct a nationwide study to assess pharmacists' knowledge on ECPs and to survey their opinion on sales category change of ECPs (i.e. to introduce OTC access in pharmacies)
Method: A prospective cross-sectional study was conducted with an anonymous, web-based questionnaire. Univariate analysis (Mann- Whitney U test and Fischer's Exact test) was used to identify factors associated with supportive opinion toward OTC provision.
Results: 357 pharmacists completed the questionnaire, yielding an 18% response rate. Almost thirty percent of pharmacists (N=99) agreed that ECPs should have an OTC availability in Hungary. More than 40% of pharmacists considered ECPs as contraceptives (N=145). In average 55.18% of answers were correct, yielding a moderate knowledge of pharmacist. Age and rating ECPs as contraceptives were significantly associated with supportive opinion toward OTC provision ($p < 0.001$). In young pharmacists (< 4 0 years) higher knowledge was also associated with more supportive attitude toward OTC availability ($p=0.02$).
Conclusion: Pharmacists' knowledge and opinion on ECPs should be improved, especially of young colleagues. Currently the attitude of pharmacists does not favor sales category changes of ECPs in Hungary.

P.029

Why French women do not use copper IUD for emergency contraception ?

Jean Guilleminot, AP-HP, France; Camille reynier, Université Paris Descartes, France

Objectives: In France, Emergency Contraception (EC) is well known and used frequently by women. The use of hormonal EC ('morning-after pill') grows steadily since its authorisation in 1999. However non-hormonal EC (insertion of a copper IUD) is used very rarely even though its efficacy is greater than hormonal EC and provides long-term contraception, too. Such situation is poorly understood and has not been studied in France. We want to understand why French women do not choose non-hormonal EC when faced with a risk of unplanned pregnancy after unprotected sex intercourse.
Methods: A paper-based anonymous questionnaire is administered to women consulting abortion and family planning centers, irrespective of the reasons of the medical consultation and their current contraception. Three centers of the Paris region participate in this study aiming at assessing women's knowledge of copper IUD as EC, barriers to its usage, and patient perceptions of copper IUD.
Results: not known at the time of abstract submission (study is ongoing)
Conclusion: to be written when results will be known (mid-2018).

Ethical Debate

P.030

Towards understanding internalised abortion stigma: listening to women's voices

Lesley Hoggart, The Open University, United Kingdom

Objectives: This presentation is located within current debates around the generation of abortion stigma. It analyses young women's narratives in order to examine internalized abortion stigma.
Methods: Two qualitative research studies in England and Wales resulting in a combined sample of 46 young women aged 16-24. Secondary data analysis on stigma resistance and rejection was undertaken.
Results: Analysis shows that whilst women felt stigmatised in relation to their abortion(s), many also resisted stigmatisation. Stigma management strategies were developed, grounded in their socio-economic situation, pregnancy context, personal beliefs and values. Feeling morally confident about their abortion decision was an important element of stigma management. Individually-held moral views interacted with socio-cultural norms around reproduction and motherhood, and shaped women's emotional responses to their abortion.
Conclusions: Our findings showed that while women undergoing abortion may internalise abortion stigma, the extent to which this is felt differs between women. It can also be resisted. Those women who were morally confident and resisted or rejected abortion stigma were least likely to struggle with their decision-making and experience negative post-abortion emotions.

P.031

Challenging abortion stigma through abortion story-telling and story-sharing

Lesley Hoggart, The Open University, United Kingdom; Victoria Newton, The Open University, United Kingdom

Objectives: This paper explores how abortion stigma can help explain negative aspects of some women's abortion experiences, such as feelings of guilt and shame, and why women who have an abortion may wish to conceal this. It also addresses what we can do to challenge abortion stigma.
Methods: We drew on a longitudinal qualitative research project we conducted with young women in England aged 16-24, who had undergone one or more abortion(s).
Results: In our research we found evidence that abortion stigma can be challenged, resisted and rejected. We decided to address this finding by developing a public engagement impact activity. The resulting project comprises a travelling interactive abortion story-telling exhibition – MyBodyMyLife – and an associated website. The proposition is that activity that challenges secrecy and silence and highlights the ordinariness of abortion can – in and of itself – contribute towards abortion normalisation and de-stigmatisation.
Outputs: MyBodyMyLife is an academic/practitioner collaboration led by the Open University. It brings academic research into the public domain by responding to the harmful impact of stigma revealed in the original empirical research, and showcasing stories generated by academic research projects. Further stories have been contributed during the course of the exhibition.
Conclusions: Storytelling is a powerful way to address abortion stigma. Visitors have commented on how their views have changed, and many visitors have contributed their own stories that demonstrate the power of the project.

P.032

The invisible "elephant in the room": why reproductive medicine needs autonomous research on the beginning of human psychic activity

Annelore Homberg, NetforppEurope, Italy; Anna Pompili, AMICA Associazione Medici Italiani Contraccezione e Aborto, Italy; Elena Monducci, NetforppEurope, Italy

Abortion providers often consider abortion in a pragmatic way: women's health has to be guaranteed. This pragmatic view has left a void, silently filled in with religious thoughts that have an apriori nature and constitute a hidden barrier to knowledge. There can be devastating consequences to this, for instance when the medical staff and the woman who asks for abortion are considered people killing a human life. Putting women's liberty of choice as the priority value doesn't seem to counterbalance this moral burden. Modern medicine considers human life linked to specific cortical activities, which allow psychic activity. The authors suggest that the "invisible elephant in the room" of medicine is the striking lack of research on brain activities which permit/indicate the presence of psychic activities, as far as the "very beginning" of psychic activity is concerned . Since the late 1960's, an unexpected contribution to this topic has come from psychiatry. An Italian psychiatrist, Massimo Fagioli, trying to understand the origin of psychotic disorders, started to wonder when human psychic activity starts. His findings have turned out to be very helpful in clinical psychiatry, also as far as post-abortion depression and professionals' burnout are concerned. His Human Birth Theory (HBT) describes the specific moment when the biological premises of the fetal condition are transformed into a primordial psychic activity.

This is at birth, due to the fetus' retina reaction to light, and the fetus cannot be provided with psychic activity before birth. In recent years, Fagioli's statements proved to be surprisingly consistent with modern neurophysiological findings. The authors suggest that discussing its contents could be helpfulto an evidence-based approach to medical knowledge also. HBT contents could present a highly original contribution when coping with the invisible elephant in the room, and thus help to define a new bioethics adequate to scientific knowledge.

Health Care Professionals

P.033

Very Early Medical Abortion (VEMA) – An international survey among providers

Mirella Parachini, San Filippo Neri Hospital, Italy; Christian Fiala, Gynmed Clinic, Austria; Teresa Bombas, Coimbra University Hospital Centre, Portugal; Aubert Agostini, APHM, France; Roberto Lertxundi, Clinica Euskalduna, Spain; Marek Lubusky, University Hospital Olomouc, Czech Republic; Kristina Gemzell-Danielsson, Karolinska Institute, Sweden

Introduction: The definition and the management of Very Early Medical Abortion (VEMA) differ from country to country. In many settings, medical abortion is delayed by the health care provider until a specific pregnancy duration or ultrasound finding. This prolonged waiting time is not only stressful for the woman, it also increases the rate of side effects and the risk for complications.
Objective: To better understand how abortion providers in Europe handle VEMA.
Methods: A questionnaire on VEMA management was developed by a group of experts with special focus on reasons for delaying medical abortion and the perceived advantages and disadvantages of VEMA. Abortion providers all over the world were invited to complete it anonymously online via a FIAPAC dedicated website.
Results: They are not available yet but will be submitted prior to the printing of the abstract book and presented at the FIAPAC conference.
This survey improves knowledge regarding VEMA management in Europe.

P.034

Expanding the role of UK maternity providers in postpartum contraception

Michelle Cooper, University of Edinburgh/NHS Lothian, United Kingdom; Karen McCabe, University of Edinburgh, United Kingdom; Lindsay McCracken, NHS Lothian, United Kingdom; Nicola Boydell, University of Edinburgh, United Kingdom; Sharon Cameron, University of Edinburgh/NHS Lothian, United Kingdom

Objectives: Increasing access to postpartum contraception can reduce unintended pregnancy and short inter-pregnancy intervals. Immediate insertion of postpartum intrauterine contraception (PPIUC) is known to be safe and effective, and is often the role of the obstetric provider. PPIUC is not routinely available in the UK and most peripartum care is provided by midwives. Our aim was to train midwives in PPIUC insertion after vaginal birth during the introduction of this service within a public maternity unit.
Methods: Local PPIUC training was modelled on RCOG "Leading Safe Choices" programme. This included theory and model simulation followed supervised clinical practice. Three supervised procedures were required to insert independently, with additional experience to become a 'trainer'. Vaginal PPIUC was introduced from January 2017 across two hospital sites. Insertion procedures were 'on demand' and performed within 48 hours of delivery.

A self-administered survey was distributed on training completion and a subset of staff were invited to take part in individual or group discussion.
Results: Twelve training sessions were delivered from January 2017 to April 2018 and 50 midwives attended. To date 19 midwives now insert PPIUC independently and 9 of these are 'trainers'. Of 218 total PPIUC procedures performed, 140 (64.2%) were by midwives, and 131 (93.6%) were successful. From completed surveys (n=42), 100% rated this as 'excellent' or 'very good', and 100% felt that the difficulty level was 'about right' or 'easy'. One of the most commonly reported challenges was immediate availability of a supervisor.
Conclusions: This training model has been effective for successful PPIUC insertion after vaginal birth. Midwives felt positive about training in PPIUC insertion and did not find the procedure too complex. Increasing the number of on-site supervisors will reduce the delivery-to-insertion interval and overcome some of the challenges perceived. Maternity unit size, staff numbers and expected uptake of PPIUC will influence the rate and availability of trained inserters.

Initiatives Politics and Society

P.035

Challenging abortion stigma: Evaluating the use of an Abortion Stories Booklet in UK abortion clinics

Victoria Newton, The Open University, United Kingdom; Lesley Hoggart, The Open University, United Kingdom

Background: The Abortion Stories booklet (My Body My Life) was developed as a method of mitigating and challenging stigma by normalising abortion experiences, through a collection of women's abortion stories. It was primarily intended for use by women in abortion clinics, to demonstrate that they are not alone in their experiences of unintended pregnancy and abortion. Using real-life stories from a number of different UK and Irish sources (e.g. Hoggart, Newton and Bury 2015; BPAS 'Anywoman' and 'Share your Stories' projects), the booklet demonstrates a diverse range of experiences and emotional responses to abortion. It shows that many women undergo an abortion, and that the decision to have an abortion is not unusual. Recent research indicates that story-telling around abortion can be one way of addressing abortion-related stigma (Cockrill and Biggs 2017).
Objectives: The evaluation explores the usefulness of an abortion stories booklet in UK abortion provider clinics, exploring how women, their partners, and staff use the resource, and the potential of the resource to be used as a model to challenge abortion stigma.
Methods: A qualitative rapid evidence evaluation at three clinic sites across the UK, involving extensive and intensive observation and multiple interviews with a broad range of stakeholders.
Results: The evaluation is on-going, but emerging findings suggest that the booklets have been well received and are also being used by partners and friends accompanying women to their abortion appointment. The needs of the support network are often overlooked and the booklets offer important perspectives on different women's experiences of abortion.
Conclusions: Sharing stories about abortion can help to address abortion stigma. Women's support networks are an overlooked area for an anti-stigma intervention.

P.036

The power of fake news and anti-choice lies – how can pro-choice groups compete?

Joyce Arthur, Abortion Rights Coalition of Canada, Canada

Anti-choice groups in Canada get millions in government funding. This presentation will tell the story of how the Abortion Rights Coalition of Canada exposed one major source of funding. Over 60 anti-choice groups were receiving federal "Canada Summer Jobs" grants to hire students. When it was revealed that one anti-choice group was using the funds to hire youth to display graphic images of aborted fetuses on city streets, the federal government responded by immediately cutting off funding for all anti-choice groups and changing the program's eligibility criteria to exclude them in the future.
But churches and religious groups created a huge backlash when they mistakenly thought the new criteria also made them ineligible. A media circus erupted, with most commentators repeating misinformation about the new criteria and drowning out fact-based corrections. Our successful effort to stop government funding of anti-choice groups was hijacked by churches, religious groups, and conservative politicians, who used a web of lies to mount a self-righteous martyr campaign and attack the pro-choice federal government. In the era of "fake news" and rampant right-wing propaganda, how can progressives get the facts out and their voices heard?

P.037

Examining manifestations of abortion stigma: preliminary findings from the SASS Study

Carrie Purcell, University of Glasgow, United Kingdom; Karen Maxwell, University of Glasgow, United Kingdom; Lesley Hoggart, The Open University, United Kingdom; Fiona Bloomer, Ulster University, United Kingdom; Sam Rowlands, University of Bournemouth, United Kingdom

Objectives: Abortion is highly stigmatised as it challenges powerful social norms of female sexuality, particularly in socio-cultural contexts where women's moral autonomy is contested. Addressing abortion stigma plays an essential part in work to remove barriers and improve access to abortion. This paper presents preliminary findings from the SASS study (Sexuality and Abortion Stigma: a Secondary analysis), the first study to specifically examine abortion stigma across the United Kingdom.
Methods: The paper explores data from recent qualitative studies with women, providers, educators and wider society in Scotland, England and Northern Ireland; together subject to qualitative secondary analysis (QSA) in the SASS study. These rich datasets are interrogated in-depth in relation to: manifestations of stigma; feelings which abortion may evoke (including shame, disgust, self-blame); and ways in which stigma is resisted/rejected.
Results: Preliminary analysis highlights ways in which negative attitudes continue to prevail and shape experiences of those seeking and providing abortion. To some extent, even those viewing themselves as broadly 'pro-choice' nevertheless found it difficult to escape broad social narratives which frame the procedure as morally questionable. Women who had undergone abortion, and those providing it, were in some cases themselves found to perpetuate stigmatising attitudes. Wider social attitudes evident in the data illustrated entrenched, socio-culturally specific constructions of abortion as predominantly negative.

Our analysis highlights the culturally constrained position of individuals who wish to challenge negative attitudes to abortion, even in contexts where it has been safely, legally provided for 50 years.
Conclusions: These findings add to a growing body of (until now primarily US-focused) scholarship which demonstrates that stigma – underpinned by gender and health inequalities – creates barriers for women seeking essential reproductive healthcare, and contributes to the medical and social marginalisation of abortion. These findings comprise the groundwork for development of an anti-stigma intervention.

P.038

What role can community-based education play in challenging abortion stigma?

Fiona Bloomer, Ulster University, United Kingdom; Kellie O'Dowd, Alliance for Choice, United Kingdom

Objectives: In societies with oppressive anti-abortion norms, such as Northern Ireland, little is known about how these norms are resisted by the adult population. This paper explores how resistance to religious and patriarchal norms can be fostered through adult community abortion education; and considers how such knowledge can inform engagement with those seeking and providing abortions.
Methods: Participants (n=17) of a community-based abortion education programme were interviewed to explore their views on abortion utilising semi-structured interviews. This paper focuses on a thematic analysis of the interview data, with a particular focus on how women resisted oppressive norms and the stigmatised positioning of abortion.
Results: The findings indicate that this resistance is multi-faceted and bolstered by a lived experience discourse, which does not necessarily involve eschewing religious notions held within society.
Conclusions: Meanings of abortion in society are constructed within socio-historical and gendered spaces and manifested through myriad discourses that impact on the perception and treatment of the issue in that society. The paper concludes that adult abortion education in community settings offers the possibility of creating dialogical spaces for people to reflect on and resist oppressive norms regarding reproduction and abortion, and in so doing can challenge stigma more broadly.

P.039

Deciphering the voices in abortion care: the woman's voice matters

Sarah Gafforini, Marie Stopes Australia, Australia; Bruce Shadbolt, Marie Stopes Australia, Australia; Michelle Thompson, Marie Stopes Australia, Australia

Objectives: When it comes to talking about abortion, there are many voices. The clinician; the nurse; the counsellor; family; the friend; and the politician. However there is one voice that is often silent – the woman. Abortion care needs to be supportive, quality-focused and patient-centred. The aim of this project is to find and amplify the voice of the woman, in turn improving her abortion care experience and outcomes.
Methods: This Australian/ UK research program has three parts: qualitative investigation of women's expectations of abortion care; development of predictive pathways that personalise abortion care; and translation of the research into practice within an implementation science framework. The first part uses focus groups to derive a set of real-world experiences and expectations from women.

Results: A workshop with stakeholders from Marie Stopes Australia has provided the research program structure. The outcomes of the workshop included: A commitment to undertake a research program in abortion care focused on “what women want”.
Research should describe women’s preferences of the journey from “start to finish”, including surgical and medical abortion; psychosocial and counselling issues; the clinician; access to contraceptives; relationship with clinicians; issues of continuity of care providers; family engagement options; financial considerations; responsiveness, effectiveness and appropriateness of care, including cultural safety; and post abortion reflection on experiences. Comparisons across populations, jurisdictions and countries. The tools, algorithms and technology coming from the research will be used to translate findings into actions. The agreement between women’s expectations found from the focus groups will be compared to the workshop results summarised above.
Conclusions: This is the first multi-jurisdictional research program of its kind in the world. Its findings will provide important applications for improving patient-centred abortion care, abortion advocacy and policy development.

P.040

A situational analysis of sexual and reproductive health and rights (SRHR) of women with disability in Moldova

Rodica Comendant, Reproductive Health Training Center, Moldova

Sexual and reproductive rights are fundamental human rights. Persons with disabilities have the same SRH needs and rights as other people. International data show that girls and women with disabilities run into many obstacles when it comes to exercising their sexual and reproductive rights.
Objective: to identify the issues confronting women and girls with disabilities in exercising their sexual and reproductive rights in Moldova.
Methods: a situational analysis methodology included: semi-structutred interviews and focus grups discussions with women with locomotor disabilities, family members, social workers and family doctors, focusing on their knowledge of SRHR, sources of information, access and quality of services.
Results: there is poor knowledge among women with disability about their SRHR, fear to have a disabled baby; low demand for services, due to existing barriers, poor knowledge where to address for services; poor access to services: lack of adapted infrastructure: lack of ramps, toilets, not adapted elevator, lack of adapted gynecological chairs. Women felt stigmatized, discriminated and coerced into making the decision to interrupt the pregnancy or discouraged to have kids when they addressed for SRH services. They mentioned low quality of services, due to services providers capacity gaps; poor knowledge of the SRR and needs of people with disability, unfriendly attitude and discriminatory behavior. At the policy level: there are gaps in policies/standards, making service providers accountable for respecting SR rights.
Recommendations: Inclusion of SRHR issues of people with disability, including mental, in national policies and programmes, development of M&E system with disaggregated indicators ;addressing the capacity gaps of the SRH service providers at all levels by updated training curriculums, education and certification opportunities; IEC for people with disability, adapted to their needs.

P.041

Croatia Today: The law that regulates abortion performed on the women's request has to be changed in the next 12 months, as the Croatian Parliament decided on Feb 21, 2017

Vesna Stepanic, Hospital, Croatia

Objectives. On February 21, 2017, the Croatian Parliament decided that the Government has two years to propose a new law that regulates abortion on the women's request. In Croatia, this matter is currently regulated by a law passed in 1978. Although the valid law is somewhat liberal, in the last 40 years, many factors that influence this topic have been occurring that simply have to be taken into consideration. Therefore, it is reasonable and necessary to change the existing Law. Methods. Two interviews by the ESC, EG on Abortion member have been published recently. In the first interview, a short look into the European Society of Contraception and Reproductive Health (ESCRH) and the Expert Group on Abortion (EG on Abortion) was provided. The rest of the interview was dedicated to the decision of the Croatian Parliament. Dr Vesna Stepanic, as an ESCRH EG on Abortion member, gave her opinion about what could realistically be expected in the next year. In the second interview, in the daily newspaper based in Zagreb, more detailed overview about this issue in the world was given, and more details about what could be expected in Croatia in the next 12 months was discussed, taking into account political situation, etc. Conclusions. Even in much more politically stable countries, it is not easy to make changes to legislation regarding abortion. In Croatia, several factions come into play: some advocate for the greater influence of the Catholic Church; whereas, others are more EU-orientated. At this time, we have a great opportunity to modernize the so-called abortion law so that it is much closer to the higher EU-standards; therefore, it is now, or never.

P.042

ICT and safe abortion access: innovative approaches to overcome barriers among users and professionals

Mel Gallo, safe2choose, Brazil; Nirdesh Tuladhar, safe2choose, Nepal

The advent and growing use of the internet has allowed innovative strategies to connect users to abortion information and services, as part of a larger movement for reproductive justice. Information and Communications Technology (ICT) have increased the possibilities of both users and providers directly accessing vital information and interactive opportunities straight into smartphones or computers.
Websites such as How To Use Abortion Pill (HTU) and safe2choose (s2c) have been promoting the autonomy of whoever decides to have an abortion by overcoming deep-rooted and often overlooked challenges such as misinformation, social stigma, physical distances, excessive medicalization, unaffordable costs, privacy concerns and personal comfort. They leverage the power of the digital revolution to address unsafe abortion practices globally. HTU is a global online resource that provides the correct usage of Misoprostol and Mifepristone - what to consider, where to acquire pills, how to use them, what to expect, and when to seek medical help if necessary. Protocols are shared in such a way that it's simultaneously clear, non-stigmatizing and medically accurate, so that it can be processed by very heterogeneous audiences, with distinct cultural, educational and age backgrounds.

More recently, HTU has embarked upon e-learning courses designed to equip professionals such as pharmacists or pharmacy workers, who are often the first point of contact for abortion in the developing world.
Alongside is s2c, a social enterprise whose mission is "to connect women all around the world to accurate information and quality, affordable abortion pills so that they can have a safe abortion where, when and with whom they feel most comfortable". The organization follows three main strategic lines: (1) providing free online and multilingual counseling, (2) facilitating access to medical abortion treatments and (3) connecting to local and global partners to fight stigma and help shifting the conversation on abortion so that reproductive autonomy becomes a reality.

P.043

Causa Hänel – Fight for the right to Information as a human right in Germany

Kristina Haenel, gp-office, Germany

The termination of pregnancy in Germany is a punishable offence, legal only under certain conditions defined in section 218. Additionally, section 219a does not allow physicians performing abortions to give information about it publicly. The law exists since 1933; first, it was used by Nazis to get rid of unpopular physicians - particularly Jews - and today, it is an excellent tool for anti-abortionists to sue physicians.
In 2017, when a charge of §219a was brought against me, I had to go public. I, therefore, started a signature campaign. The media response and support of people and institutions were huge. In November 2017, I was sentenced to 6000 euros. More physicians were reported because of their homepage or because of a cover of a newspaper with their photos saying “I perform terminations of pregnancy”. In December, a petition pressing for a change was submitted to the German Bundestag. Meanwhile, a nationwide movement for women's and human rights had emerged. Either politics will improve the legal framework or I will legally try to obtain a change.
§219a is still effective and bans the objective information by physicians about abortions. That anti-abortionists have the uncontested informational sovereignty on the Internet is the result. They can spread unobjective, distressing misinformation concerning abortions, defame physicians and traumatise women seeking help (e.g. http://www.babykaust.de/). Less and less physicians are willing to offer abortions under these circumstances, and teachers do not dare to train young physicians. There are no German guidelines to the termination of pregnancy.
Germany has to face the strengthening of right force. Thus, one cannot avoid the impression that the political élites seek increasingly the alliance with the populists to meet today’s zeitgeist. Although most parliamentarians agree with the Pro-Choice movement, politics is incapable of acting which causes sensation also in the international press.

P.044

Improving access to abortion in remote and rural Australia with a telehealth at home service

Catriona Melville, Marie Stopes Australia, Australia

Background: Access to abortion in some areas of Australia is challenging due to geographical remoteness and a lack of local abortion providers.

This is compounded by legislation which varies by state and stigmatisation in small and often conservative rural communities. Additionally women can be fearful of a perceived or genuine lack of confidentiality and privacy in regional areas.
Methods: Marie Stopes Australia (MSA) provides abortions and contraception throughout Australia. Most procedures are arranged via a face-to-face appointment however to overcome barriers to access in remote communities, MSA launched a telehealth at home (THH) medical abortion service in late 2015. Pre-procedure investigations (blood group, serum HCG and ultrasound scan) are undertaken by providers local to the client. A pre-care telephone consultation is then arranged with a nurse. Subsequently a telephone consultation with a doctor takes place which includes an electronic consent process. Medications for medical abortion (MS-2 step) and analgesia are dispensed and couriered directly to the patient. Follow-up is completed via a post-care telephone consult.
Summary: Our presentation gives an overview of our THH medical abortion protocol and the characteristics and outcomes of the first 1000 clients undergoing MTOP via the THH service. We also illustrate some of the unique challenges faced by women seeking abortion in Australia by sharing case studies.

Legal Aspects

P.045

Why Abortion is still in the Penal Code in Belgium ?

Sylvie Lausberg, Centre d'Action laïque asbl, Belgium

In Belgium, policies restricting sexual freedoms were particularly strong up to the end of the 20th century. The dominant presence of Catholic parties in coalition governments in fact prevented any significant change until the law partially decriminalising abortion was adopted in 1990. This overdue law made its mark on the country's institutional and social history in more ways than one. Enshrining a de facto situation of civil disobedience of doctors illegally carrying out abortions under good medical conditions, the so-called 'Lallemand-Herman-Michielsens' law did not meet the request of practitioners and feminists to fully remove abortion from the Belgian penal code. This law partially decriminalising abortion was, moreover, adopted under unprecedented circumstances; King Baudouin, a fervent Catholic, refused to sign the law as required of his constitutional role. This could have been nothing other than an incident. However, although the country now has the most progressive legislation in Europe on homosexual marriage (2003) and on adoption by homosexual couples (2006), legislation on abortion remains part of the penal code, listed under the heading "Crimes and offences against family order and public morality." The stringent and cumulative conditions set out in the law to ensure that criminal sanctions are not applied were and remain, as such, concessions to opponents of abortion. Belgian society, including the media, has been slow to recognise the symbolic, political and legal significance of this persistent view of abortion as a criminal offence, non-repealed but pardoned under certain conditions. Acceptance of abortion as a personal choice and not as an instrument of control over women is an indicator of a state's level of democracy and its egalitarian views.

P.046

Knowledge and attitude of first year undergraduate students in Addis Ababa university on liberalization of safe abortion

Yitbarek Fantahun, Addis Ababa University, Ethiopia

Objective: The aim of this study is to assess knowledge about the existing abortion law in Ethiopia, the attitude of respondents towards legalization of abortion and factors associated with it among Addis Ababa university first year undergraduate students in Addis Ababa city, Addis Ababa, Ethiopia.
Method: Institution based-cross-sectional study design involving both quantitative and qualitative methods was employed. The sample size was 844 and Participants were selected out of all undergraduate programs which enrolled undergraduate students during the 2014/15 academic period by random sampling technique and sample will be proportionally allocated. Data was analyzed using SPSS version 21.0. The analyzed data was presented using tables and texts
Result: From all the respondents, 298 (35.3%) of the students are knowledgeable about the abortion law in the country whereas 24 (2.8%) of the respondents have incorrect knowledge and 522 (61.8%) of the respondents have no knowledge about the existing abortion law in Ethiopia. Department of study, the collage of study, monthly family income and history of family planning use had an association with knowledge. conserning attitue,166 (19.7%) respondents have positive attitude for legalization of abortion for any circumstances whereas 678 (80.3%) have negative attitude for legalization of safe abortion for any circumstance
Conclusion: Only one third of students found to have adequate knowledge about the existing abortion law in Ethiopia. The department of study, the collage of study, monthly family income and history of family planning use were found to have influence on Knowledge of the existing abortion law. Nearly one fifth of the students have positive attitude for legalization of safe abortion for all circumstances. The department of study, the collage of study, the owner of the school before joining university and the monthly family income were found to have influence on attitude towards abortion law.

P.047

Introduction of MtoP in Croatia

Herman Haller, University Clinical Hospital Rijeka, Croatia

Croatia, european country with positive abortion (intended pregnancy termination) - law regulation (from 1978), actual situation, ordinary practice, statistics. Introduction of mifepriston and misoprostol in pregnancy termination – initial experience of single institution Support in expanding the metod of medical pregnancy termination throughout the country and region. The use of medical pregnancy termination in early pregnancy loss – our experience.

P.048

www.abort-report.eu: A new website to share information on fertility, contraception and abortion

Teresa Bombas, Coimbra University Hospital Centre, Portugal; Aubert Agostini, APHM, France; Kristina Gemzell-Danielsson, Karolinska Institute, Sweden; Roberto Lertxundi, Clinica Euskalduna, Spain; Marek Lubusky, University Hospital Olomouc, Czech Republic; Mirella Parachini, San Filippo Neri Hospital, Italy; Christian Fiala, Gynmed Clinic, Austria

Objective: Abortion is legal under certain conditions in most European countries. However, legal and practical conditions vary widely.

To improve knowledge and better disseminate information on abortion in Europe and allow comparison between the different legal and practical conditions, it was decided to collect European data on abortion on a website to be regularly updated.
Design and methods: A scientific committee of 7 European gynaecologists / obstetricians, supported by Exelgyn was constituted. The authors selected the items and invited gynaecologists / obstetricians practising in European countries (i.e., the 28 EU country members + Iceland, Norway and Switzerland) to participate in the project. Two questionnaires were developed and prefilled with country official data. Questionnaire I (85 items) focused on abortion legislation, and Questionnaire II (116 items) on practical and statistical data on abortion, fertility and contraception. The questionnaires were sent by e-mail to all gynaecologists / obstetricians who agreed to participate (correspondents). Correspondents validated, updated, and/or completed the questionnaires.
Results: Questionnaire I was sent to 29/32 correspondents (abortion is prohibited in Malta and there was no correspondents for Romania and Slovakia) and completed for 22/29 countries (76%). Questionnaire II was sent to 22/29 correspondents and completed for 15/22 countries (68%). Questionnaires I provided data for >90% of items for 19/22 countries (86%) and Questionnaire II for >70% of items for 8/15 countries (53%). Missing data were mainly related to abortion costs and contraception statistics.
Conclusions: The www.abort-report.eu website will constitute a unique and synthetic source of information on abortion in Europe for health care professionals and all other professionals. It will provide information on abortion legislation and abortion, fertility rates and contraception statistics per country and give a European perspective on abortion. It may be used as a complement to the website on abortion policies recently launched by the WHO: http://srhr.org/abortion-policies/.

P.049

Developments in abortion legality from 2008 to 2018: a global review

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Objective: Evidence shows that restricting abortion does not eliminate its practice, but leads women to conceal their abortions, which makes them less safe. We need to periodically assess legislation to monitor how reform affects women's ability to have safe and legal abortions.
Methods: We analyze the relationship between abortion legality, using a six-category continuum from banning abortions to allowing them on request, and countries' income level worldwide. We also quantify countries by the three extra-continuum grounds of rape, incest and fetal anomaly. Changes over time from 2008 through 2018 along the continuum and in the extra-continuum criteria are examined, as are the pathways that led to reform. We also quantify consent requirements and provisions in penal codes that charge women for the crime of abortion.
Results: Legality correlates positively with income: The proportions of countries in the two most-liberal categories rise uniformly with gross national income. Among countries eligible to enact extra-continuum grounds, 33% have all three, and 51% have none. As of 2017, the vast majority—93%—of countries that restrict abortion have laws that criminally charge the woman. From 2008 through 2018, 15 countries expanded legal grounds for abortion. Notable reform resulted from a range of actions, most often through combined strategies.

These include presenting evidence of improved outcomes from harm-reduction efforts; medical societies highlighting harm to women's health; local champions spearheading reform; and appeals to comply with treaty obligations.
Conclusions: The lifting of draconian laws in highly restrictive settings is happening in tandem with procedural barriers being erected in several countries that allow abortion on request. To simultaneously address these opposite developments, we need to continue to collect and disseminate research on how safety improves once women are no longer compelled to seek clandestine abortions.

P.050

Restrictions in access to abortion: Opinion of women having an abortion - A comparison of Hungary and Austria

Christian Fiala, Gynmed Clinic, Austria; Jennifer Kernreiter, Gynmed Clinic, Austria; Diana Lusztig, Gynmed Clinic, Austria

Introduction: In Hungary women have to attend an obligatory 'counseling' and respect a 'waiting period' before a legal abortion. Such restrictions do not exist in Austria. The restrictive Hungarian abortion law drives many women seeking an abortion to Austria. Limited information is available about the perception by women and the efficacy in reducing abortions.
Material & Methods: Between November 2017 and April 2018, a questionnaire was given to women from Hungary and Austria who were fluent in the respective language. Outcome measure was women's experience and perception about abortion restrictions, whether they found them helpful or distressing and the possible impact on their decision. The seventeen-item questionnaire included one open question. The two groups were clustered for descriptive statistics and t-test independent sample analyses. The one open question was analyzed with qualitative measures.
Results: The majority of women were opposed to compulsory counseling and obligatory waiting period. They perceived restrictions in access as not helpful but as further increasing their stress. Also the vast majority (85% from Hungary and 76% from Austria) clearly stated that restrictions did not or would not have changed their decision for the abortion. This is true for women who are subject to these legal restrictions as in Hungary. But it is also true for women who don't have these restrictions and consequently have an easy access to abortion like in Austria. Women who are subject to restrictions (from Hungary) disapproved them in a significantly higher percentage than women who don't have to follow them (from Austria), 91% vs 68%.
Discussion: Most women coming for an abortion supported the legal situation in Austria with easy access. The study's provides strong evidence for unrestricted access to abortion, with restrictions like obligatory counseling and waiting periods adding to the stress of women without any benefit.

P.051

Experiences of women accessing an abortion clinic contacted by religiously motivated demonstrators - a pilot study

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Objectives: Women who entered an abortion clinic have occasionally been contacted by

religiously motivated demonstrators. The contact was either speaking to the women, and/or handing over a plastic embryo or a religious pamphlet. Women who had been contacted were asked about their experiences and possible influences on their decision.
Study Design: 101 women between the age of 12 and 47 years completed a questionnaire. T-test independent sample analyses methods were used to determine the association between the women's decision about an abortion and the contact.
Results: Some women (17%) were physically harassed, for instance by being hindered to enter the building. 99% of the women found the contact annoying. 81% of the participants said that the protestors had no influence on their decision, while 18% of the women reported insecurity to various degrees. 93% of participants supported a legal ban for protests close to abortion clinics.
Conclusions: The activists main goal, or ´spiritual fight`, of preventing abortions (`saving souls´) was not reached. Their actions had little, if any, impact on the women's decision. However, the contact with the protestors can be stressful for women of concern. Further research on the negative effects of exposure to protestors on the women's mental health (e. g. feelings of guilt) and physical health (e. g. associated with postponed appointments for the abortion) is necessary. The results of the survey stress the need for enhanced protection for women entering abortion clinics. The most obvious solution would be the implementation of 'safety zones' around abortion clinics or a legal ban of approaching women accessing an abortion clinic.

Medical Abortion

P.052

How to increase access to medical abortion

Marion Ulmann, Linepharma, United Kingdom

Linepharma has registered Mifepristone in more than 25 countries around the world. Each country has a different regulation and each registration is unique. It is always a long process to register Mifepristone, and administrative, financial and political hurdles must be overcome. Support of local ob/gyn, activists, patients, NGOs is needed to expand medical abortion, and to convince regulatory agencies and government that medical abortion is safe. Sharing three difference experiences of registration and distribution plan of Mifepristone:
Registration in Europe (France, UK, Scandinavia): long registration process, liberal distribution plan in Europe, partial reimbursement. Registration in Canada: long and expensive registration process, liberation distribution plan (delivery in pharmacies) full reimbursement. Mexico: long and expensive registration, restrictive distribution plan, no reimbursement.
Conclusion: Increase access to medical abortion is a collaboration between pharmaceutical company and the local medical society. Without a strong local network, pharmaceutical company cannot expand access medical abortion alone. It is necessary to have doctors and patients involved.

P.053

Outcomes of medical abortion in women with a scar on the uterus after cesarean section

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The information presented in the literature on the incidence of complications of medical abortion (MA) performed in the early period in women with uterine scar (US) after cesarean section is controversial: most authors indicate no difference in the outcomes of MA compared to women with intact uterus. Au H.-K. et al. (2015) determined the dependence of unsuccessful outcomes on the thickness of the scar according to ultrasound.
Materials and methods. 352 women with an undesired pregnancy in terms up to 42 days of amenorrhea, including 26 with US (7.6%) and 216 (92.4%) with intact uterus. Used: mifepristone 200 mg, after 36-48 hours – misoprostol 400 μg orally. Control of the effectiveness of MA was carried out with the help of ultrasound on the 10-14th day after mifepristone.
Results. Complete MA occurred in 96.2% (25/26) of women with US and 99.1% (214/216) with intact uterus (p = 0.739, relative risk, RR 0.97, 95% CI: 0/90-1.05). Fetal egg expulsion for 3 days or more occurred in 19.2% (5/26) and 9.7% (21/216) of women, respectively (p = 0.253, RR = 0.90, 95% CI: 0.74-1.09). Instrumental revision of the uterus cavity required 7.7% (2/26) and 0.9% (2/216), respectively (p = 0.081, RR = 0.93, 95% CI: 0.83-1.04). Indications for revision were: retention of the fetal egg in the uterine cavity in 3.8% (1/26) of women with US and 0.9% (2/216) - without scar (p = 0.739, RR = 0.97, 95% CI: 0.90-1.05), bleeding in 3.8% (1/26) and 0.5% (1/216), respectively (p = 0.513, RR = 0.97, 95% CI: 0.89-1.04).
Conclusion: The efficacy of MA in terms up to 42 days of amenorrhea in women with US is 96.2% and is not statistically different from 99.1% of women with an intact uterus. There is also no statistically significant difference in the incidence of complications requiring instrumental revision of the uterine cavity.

P.054

Fatal bleeding during medical abortion in woman because of the rise of chorion in the scar on the uterus after cesarean section. Clinical observation

Galina Dikke, Peoples' Friendship University of Russia, Russian Federation

Patient V., 33 years old. In the anamnesis there are 2 caesarean sections. The present pregnancy is the third, the term is 6 weeks. According to the ultrasound on the anterior wall of the uterus is a postoperative scar 2.8 mm thick, the fetal egg 19x7 mm – In the uterine cavity and adjacent to the scar, the chorial tissue is located at the periphery of the fetal egg, unchanged. Drugs were used for medical abortion (MA): mifepristone 200 mg, in 48 hours – misoprostol 400 μg orally at home. Control of the effectiveness of MA was carried out with the help of ultrasound on the 11th day. Ultrasound for the 11th day: the cervical canal widened to 28 mm with the fetal egg. The fetal egg is visualized by the doctor in the vagina during the gynecological examination, there is no bleeding. The patient's condition is satisfactory, the body temperature is 36.5 degrees C, the breathing rate is 16 per min, the heart rate is 80 beats per minute, the blood pressure is 105/55 mm Hg (working).

On the 15th day during the gynecological examination began spotting. Measured blood pressure – 70/30 mm Hg. The blood loss was 400 ml. The patient was hospitalized in a hospital. When entering the hospital the patient's condition is extremely difficult. US – suspicion of uterine scar rupture, hemoperitoneum. Hemoglobin – 14 g / dl. Surgical stopping of bleeding was undertaken when the patient was in a state of clinical death on the background of resuscitation. Rupture of the uterus was not confirmed. The total volume of blood loss was 3000-3500 ml. The immediate cause of death was hemorrhagic shock due to massive blood loss as a result of the ingrowth of chorionic villi into the myometrium in the postoperative scar.

P.055

Efficacy of the mifepristone - prostaglandin analogue combination in medical abortion before and after 7 weeks of amenorrhea. RYMMa study

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Objective: Evaluate conditions and success rate of medical abortion (MA) before 7WA and between 7 and 9WA with 600mg of mifepristone in current practice.
Material and method: RYMMa is a prospective longitudinal observational study conducted in 23 hospitals. Primary objective: evaluate the success rate of MA before 7WA and between 7 and 9WA. Secondary objectives: report the conditions of prescription of the associated prostaglandin and the factors influencing the success of MA.
Results: Between Nov 2015 and May 2016, 893 patients were included, of whom 490 (55%) and 403 (45%) for MA before and after 7WA respectively. These two groups were comparable in terms of socio-demographic data and of pregnancy and abortion history. MA success rates were of 94.5% [91.9-96.5] and 92.4% [89.1-94.9] (p = 0.2), respectively before and after 7WA. The most used prostaglandin was misoprostol (99.7 and 88.3%). The most common doses were 400 µg (75 and 51%) and 800 µg (19 and 38%). Routes of administration of misoprostol were oral (63 and 45%), buccal (16 and 19%), sublingual (14 and 19%), vaginal (7 and 14%) or mixed (oral and vaginal) (0.5 and 3%). Gemeprost was used in 0.2% of cases before 7WA and in 11.7% of cases after 7WA. Additional misoprostol intake after MA was performed in 8.1 and 9.7% of cases respectively. Factors influencing the success rate (multivariate analysis): number of pregnancies, number of previous surgical abortions, delay between mifepristone and prostaglandin intakes. The term was not an influencing factor.
Conclusion: Success rates of MA before 7WA and between 7 and 9WA were equivalent in current clinical practice in centers performing MA up to 9WA with 600mg of mifepristone. Misoprostol was the most used prostaglandin regardless of the term with doses varying according to the term.

P.056

Self-managed Abortion – A Progressive Advocacy Agenda.

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Objectives: Traditionally, the benefits of self-managed medical abortion were seen only in the reduction of death and injury, with care provided by formal health systems as the standard

to which all should aspire. In both restrictive and less restrictive legal settings, however, people self-manage their abortion for diverse reasons: necessity, convenience and preference. We propose reframing this action as part of a progressive advocacy agenda for abortion rights and access.
Methods: This presentation will draw on the experience and conceptual frameworks of Women Help Women and multiple feminist activist partners across the globe. Many of their practices are based in innovation, such as use of telemedicine, m-health and task shifting to lay health workers. These advocates and activists assist those in need of abortion in restrictive settings to access mifepristone and misoprostol and work with multidisciplinary researchers to establish new narratives around the practice.
Results: Self-managed abortion is a valid alternative to services provided by formal health systems and should not to be stigmatized as a sub-standard "second-best" practice. New discourses and practices based in harm reduction, human rights and community activism are changing the narrative on self-management from a survivalist strategy to an alternative way of organizing and delivering safe abortion care through building activist resistance and empowering those involved.
Conclusion: A different paradigm is needed to capture the potential of self-managed abortion, e.g. re-definition of provider, quality of care, as well as changes in regulatory frameworks that almost universally criminalize self-use. Instead of positioning self-managed abortion on the outskirts of the mainstream abortion provision, or in opposition to safe, legal abortion care provided by health systems, critical thinking is needed how to integrate lessons learned from these novel practices to revitalize and improve health care systems.

P.057

600 mg mifepristone +400 µg oral misoprostol vs 200 mg mifepristone + 800 µg vaginal misoprostol for early medical abortion

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The aim of this study is to know the posible difference between the protocols above enunciated . Although the published results of these protocols do not have meaningful differences regarding their effectiveness , it has not been shown that safety does not have significant differences.
MATERIAL and METHODS: 2520 pregnant women up to 8weeks randomized to receive 600 mg of mifepristona + 400 µg por oral misoprotol (group A) or 200 mg mifepristone + 800 µg of vaginal misoprostol (group B) in 7 centers of Spain , Portugal and Cuba .
RESULTS: the average gestational age was similar in both groups. The succes rate with complete abortion were 89.10% vs 87.30% in groups A and B respectively. The side effects after misoprostol were : nauseas 29,0% and 30.3% (p: 0,59), vomiting 16,7% and 22.4% (p:0,007), diarrhea 12,8% and 17,7% (p:0,010), fever: 3,8% and 11,2% (p: 0,00), chills: 22,4% and 36,3% (p: 0,00), average pain with VAS scale was 5,37 and 6,00 (p: 0,00) in groups A and B , respectively. The complete abortion rate was higher in some centers arriving to 97,30% and 92,60% (p: 0,312).
CONCLUSIONS: Regarding the succes rate there were not significatives differences between both groups but in group B there were significatively more vomiting, diarrea, fever, chills and pain.

The complete abortion succes is very variable depending on the research center taking into account if the center has used abdominal scan in the post abortion followers up process or not.

P.058

Extending medical home abortion up to 70 days' gestational age in a Swedish setting- an interim analysis

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Objectives To evaluate the efficacy and acceptability of home administration of misoprostol up to 70 days' gestational age
Methods Women seeking medical home abortion up to 70 days were invited to participate in the study. They were stratified in two groups due to gestational length, up to 63 days or 64-70 days. In both groups Mifepristone was administered at the clinic and Misoprostol was administered by the woman at home 24-48 hours later. Primary outcome was success of treatment, defined as complete abortion without the need for further intervention. Secondary outcomes were adverse events, reported pain and level of satisfaction. Required sample size was calculated to be 500 participants.
Results This is an interim report after inclusion of 112 subjects,77 in the early group and 55 in the late group. Primary outcome was assessed for 62 women in the early group and 50 women from the late group. Mean age of the participants was similar 27.5 years (18-46) and 29 years (18-44) for early and late groups respectively. Success rate was 95.2% for the early group and 96% for the late group. In the late group one ongoing pregnancy was found and the pregnancy was terminated medically. Surgical intervention was performed in one woman in the early group and two in the late group. Medical interventions were performed in three cases in the early group and in two cases in the late group. Total days of bleeding were 13.7 + 5.6 in the early group and 16 + 7.2 in the late group. Most women in both groups found the abortion method acceptable regardless of gestational length.
Conclusions The preliminary results support that home use of misoprostol in medical abortion is safe and well accepted up to 70 days of gestation.

P.059

Assessing the safety and effectiveness of medical abortion medications purchased from pharmacies

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Objectives: Women seeking abortion in low- and middle-income countries often turn to pharmacies. Evidence on the outcomes of women who self-administer medical abortion purchased from pharmacies is lacking. This study aimed to establish the clinical outcomes of women who self-administer misoprostol or mifepristone+misoprostol purchased from pharmacies in Bangladesh.

Methods: A prospective cohort study followed women purchasing mifepristone+misoprostol or misoprostol-only from 110 pharmacies in Bangladesh. Participants were recruited by pharmacy workers either in-person or indirectly via the purchaser of the drugs. End users were contacted by phone two weeks after recruitment, screened and interviewed.
Results: Recruitment rates by pharmacy workers were low (30%), but 2-week follow-up rates were high (87%). Of the 109 end-users interviewed, 87 purchased mifepristone+misoprostol and 20 misoprostol-only, while two women did not know what drugs they had purchased. Mean self-reported number of weeks of pregnancy was 5.7 weeks. Respondents reported receiving very little information from pharmacy-workers about the medications (40.4% received none), and most (90.4%) did not have their eligibility for taking the medication assessed. A total of 80.5% of mifepristone+misoprostol users were sold the correct regimen versus 9 out of 20 misoprostol-only users. A total of 68.8% did not report experiencing any complications (70.0% misoprostol-only; 69.0% mifepristone+misoprostol users, p=1.0). A total of 94.3% of mifepristone+misoprostol users and 75% of misoprostol-only users reported that they were not pregnant at day 15 (p=0.020). However, 7.3% of all users sought additional treatment.
Conclusions: Challenges in assessing outcomes of self-managed menstrual regulation medications purchased from pharmacies must be overcome through further development of this methodology. Our study provides preliminary positive evidence on the safety and effectiveness of self-management despite low information provision from pharmacy workers. Interventions are urgently needed to ensure that women have access to correct dosages, accurate information and necessary referrals.

P.060

Program adherence, safety, and effectiveness of home-use of misoprostol (in combination with mifepristone) between nine and 12 weeks' gestation: Findings from IPPF Member Association clinics

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Objectives: We aimed to document and describe women's experience with home use of misoprostol (with clinic-administered mifepristone) between nine and 12 weeks' gestation to determine the safety and effectiveness of this regimen in the later part of the first trimester.
Methods: Client data for the period 1 January 2016 through 31 December 2016 from six sites in two IPPF program countries were reviewed to identify women who received medical abortion services. The services received and outcome of the abortion, including complications (i.e. bleeding, incomplete abortion, continuing pregnancy, or severe pain), were abstracted. Clients between nine and 12 weeks' gestation were included. Summary statistics were used to describe the population.
Results: In 2016, 579 medical abortion clients were seen across the two programme sites; 60 clients (10%) were nine to 12 weeks' gestation, 26 from four clinics in Benin and 34 from one site in Burkina Faso. Median recorded gestational age was 10 week. Clients varied greatly by age (range: 16-45, median=27), parity (range: 0-10, median=0), and gravidity (range: 0-10, median=3). Adherence to clinic protocol was high; all clients received a bimanual exam and counselling prior to receiving 200mg of mifepristone in clinic and 800mcg of misoprostol, which was taken sublingually at home. The median time between administration of mifepristone and misoprostol was one day (range: 0-2). Among this cohort, no complications were recorded and all women had a complete abortion.

Conclusions: While additional research is needed to determine the safety and effectiveness of home use of misoprostol between nine and 12 weeks' gestation, these findings indicate that such a service is safe and effective across a variety of demographic groups. These results also demonstrate that, when counselled, women can effectively self-administer misoprostol. Future work should evaluate the impact of home use of misoprostol after nine weeks' gestation on client acceptability and satisfaction measures.

P.061

Providing telemedicine abortion care in Poland: An analysis of 18 months of service delivery through Women Help Women

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Poland has one of the most restrictive abortion laws in Europe. However, tens of thousands of Polish women obtain clandestine abortions annually through private sector clinics, abortion tourism and travel to other countries, and, more recently, online telemedicine providers.
Objectives: Women Help Women (WHW) has operated a non-profit medical abortion telemedicine service in Poland since 2014. Our study aimed to evaluate the use patterns and outcomes associated with 18-months of WHW's telemedicine service delivery in Poland.
Methods: We examined the logs that WHW collected between January 1, 2015-June 30, 2016. We analyzed both questionnaires using descriptive statistics (close-ended questions) and for content and themes (open-ended questions).
Results: During the 18-month study period, more than 1000 Polish women completed the online consultation. We will present results and statistics of gestational age of women that asked for medication, contraceptive use among the users of the service, reasons for seeking termination, follow-up rates and outcomes of the procedure.
Conclusions: WHW is a major provider of abortion care for Polish women. Our findings suggest that women accessing abortion services through WHW are generally not eligible for a legal abortion in Poland. The outcomes are reassuring and suggest that telemedicine provision of mifepristone/misoprostol is an acceptable and effective strategy for expanding access to safe abortion services.

P.062

Using medication for menstrual regulation outside health facilities in Bangladesh

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Objectives: Abortions are restricted in Bangladesh, and menstrual regulation (MR) exists as an alternative. Women commonly seek medication for MR outside health facilities yet little is known about these women. Unregulated abortions can be dangerous and we aimed to understand more about these women; why they did so, why they chose the provider they did, how they obtained the medication, and their experience using it.

Methods: In 2015, we conducted a multi-method qualitative study in urban and peri-urban Dhaka including 43 interviews with women who had undergone MR outside health facilities, observation of official and unofficial facilities for MR, and informal interviews with key stakeholders. Fifteen of our interviewees had used medication for MR from pharmacies or informal providers of manual vacuum aspiration.
Results: Women obtained medications for MR from pharmacies and informal providers of manual vacuum aspiration, most commonly indirectly via a third party, e.g. a family member. Only one woman knew what medication she had used. Many deemed their procedure to have been unsuccessful, suggesting that they may have used ineffective medications or incorrect doses or not known how to recognize a successful MR. After medication failure, women often returned to the same informal providers for further unregulated, more invasive services and only sought care from official sources after exhausting other options.
Discussion: Women were able to source medication for MR, but did not have enough information or support to ensure they took the correct medication and the correct dose. Our interviewees experienced unsuccessful procedures and sometimes painful and distressing sequelae. Our findings suggest that a comprehensive intervention is needed to improve knowledge and use of medications for MR not only among pharmacists and drug sellers, but also among MR clients and their family members. Wider provision of combi-packs of mifepristone and misoprostol may improve the situation.

P.063

What difference between 48 and 72 hours in the RU486-prostaglandin protocol?

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Italian law requires that abortion drugs shoul be giving in hospital setting. For this reason we give mifepristone on Monday, Tuesday and Wednesday. In order to increase the offer we started to give it on Friday and the prostaglandin after 72 hours on Monday. We We compared the rate of surgery in the two groups over the last four years.
From 2014 to 2017 we had 5,978 medical procedures, 4,717 abortions and 1,261 missed abortions. The medical procedures with 48-hour interval were 3,979 (84.4%) abortions and 1062 (84.2%) missed abortions, while those with a 72-hour interval were 738 (15.6%) abortions and 199 (15.8 %) missed abortions. For abortion the rate of surgery was 2.11% for 48 hours versus 5.96% for 72 hours. For missed abortion the rate of surgery was 4.9% for 48 hours versus 3,5% for 72 hours.
The conclusion is that there are no differences betwen 48 and 72 hours of interval for missed abortion, but there is a three fold increase for abortions. So we are considering to limit the 72-hour interval to mixed abortions and to consider the 24-hour interval for abortions by giving mifepristone on Thursday and prostaglandins on Friday.

2014-2017	48 h		72 h		Totale	
Abortion	3.979	84 (2,1 %)	738	44 (6,0 %)	4.717	128 (2,7 %)
Missed Ab.	1.062	52 (4,9 %)	199	7 (3,5 %)	1.261	59 (4,7 %)

P.064

Survey about current practices of medical termination of pregnancy in France in 2018. The AbY survey.

Aubert AgostinI, Hôpital La Conception, France

Objectives: In December 2016, the French National College of Obstetricians and Gynecologists (CNGOF) published guidelines on Medical Termination Of Pregnancy (MToP). The present survey aimed to record actual practices of MToP in France and to observe whether they were influenced by recent CNGOF recommendations.
Methods: Between January and March 2018, the online survey link was sent by email to all CNGOF members and to the French National Union of Obstetricians and Gynecologists. Further, the same survey will be sent to all the midwifes, members of the National College of midwives. Practitioners were asked to report their personal current practice independently of the protocols established in their hospitals or abortion centers.
Results and conclusion: Survey collection being in progress, hereafter are presented preliminary data. Out of the 395 collected surveys, 243 (61,5%) concerned prescribers performing MToP, 201 (83%) of which were obstetrician/gynecologists. For terms up to 7 weeks of amenorrhea (WA), the most frequently used protocols include 600 mg of mifepristone (50.6%) with 400 µg of misoprostol (73.3%) by oral route (54.7%). Among the prescribers, 44,8% of them report having less than 1% of on-going pregnancies, and 48,8% prescribe NSAIDs before pain. Only 138/243 (55,6%) prescribers declared performing MToP after 7 WA, and 12.4% after 9 WA. For MToP after 7 WA, the most frequently used protocol is 600 mg (48,9%) of mifepristone with initial dose of 400 µg of misoprostol (49,6%) by oral (38%) or buccal (29,2%) route. Among the prescribers, 37,7% of them report having less than 1% of on-going pregnancies, and 56,9% prescribe NSAIDs before pain.
Even if over half of prescribers (53%) declared that CNGOF's guidelines were helpful in their clinical practices, only 42.9% of them reported a subsequent change of their current practice.

P.065

Management of Medical Termination of Pregnancy (MToP) up until the 7th week of gestation in the Czech Republic

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Objective: In the Czech Republic (CR), it is possible, to carry out Medical Termination of Pregnancy (MToP) in the 1st trimester since June 2014, in case a woman submits a written request for it and in case the ultrasound examination confirms an intrauterine singleton prosperous pregnancy, between day 42 and 49 of gestation, crown-rump length (CRL) of the embryo 2-9 mm. The aim of the study is to analyze the management of MToP up until the 7th week of gestation in five centres in the CR.
Methods: In 2014-2016, a total of 1820 pregnant women requested MToP. The diagnosis of an intrauterine singleton prosperous pregnancy was set by transvaginal ultrasound, CRL 2-9 mm. MToP was carried out by combination of mifepristone (600 mg orally) and misoprostol (400 mcg orally) within 48 hours. MToP follow up (exclusion of ongoing pregnancy) after 2-3 weeks was carried out by transvaginal ultrasound as well.
Results: In 11.0% of women (201/1820) who requested MToP, CRL > 9 mm, unprosperous, multiple or ectopic pregnancy was diagnosed. In the remaining 1619 women MToP was carried out, the diagnosis of intrauterine singleton prosperous pregnancy CRL 2-9 mm could be established.

In 20.8% of women (336/1619) MToP follow up was missed and of the remaining 1283 women, ongoing pregnancy (MToP failure) was diagnosed in 1.6% (21/1283), incomplete abortion in 6.5% (83/1283) and complete abortion in 91.9% (1179/1283). A subsequent surgical intervention was carried out in 7.4 % of women (95/1283).
Conclusion: A medical facility performing MToP in the 1st trimester should develop its own methodology in accordance with the legislation in force, Summaries of Product Characteristics, and recommendations of professional associations. The methodology should also include a method of evaluation of the result and management. The subsequent surgical intervention should only be performed in indicated cases.

P.066

Medical termination of pregnancy (MToP) in the first trimester – the role of hCG and ultrasound in pregnancy diagnosis and MToP follow-up

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Objective: In the Czech Republic (CR), it is possible, to carry out Medical Termination of Pregnancy (MToP) in the 1st trimester in case the ultrasound examination confirms an intrauterine singleton prosperous pregnancy, between day 42 and 49 of gestation, crown-rump length (CRL) of the embryo 2-9 mm. The aim of the study is to analyze the importance of serum/urine human chorionic gonadotropin (hCG) assessment and ultrasound (US) examination in pregnancy diagnosis and MToP follow-up.
Methods: In 2016-2017, MToP was carried out in a total of 109 women. The diagnosis of an intrauterine singleton prosperous pregnancy was set by transvaginal ultrasound, CRL 2-9 mm. MToP was carried out by combination of mifepristone (600 mg orally) and misoprostol (400 mcg orally) within 48 hours. Serum/urine (low sensitivity urine pregnancy test, LSUP test) hCG assessment and US examination was perfomed in pregnancy diagnosis and MToP follow-up after 2-5 weeks.
Results: In pregnancy diagnosis, there was a medium strong positive correlation between serum hCG and gestational sac (r = 0,711; p 1000 IU/l was present in 13.8% of women (15/109) and positive LSUP test in 17.4% (20/109). US examination diagnosed ongoing pregnancy in five women and missed abortion in one woman (serum hCG was always > 1000 IU/l and LSUP test always positive). In 5.5% of women (6/109), a subsequent surgical intervention was carried out including ongoing pregnancy (n = 5); missed abortion (n = 1) was treated by additional misoprostol, not by surgery.
Conclusion: In MToP follow-up, a negative LSUP test enables reliable exclusion ongoing pregnancy and missed abortion, in case of a positive LSUP test, US examination should be performed; however,surgical intervention should not be indicated solely on the basis of uterine cavity dilatation.

P.067

The role of info given by pharmacists in medical abortion in Bulgaria

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Introduction: Medical abortion is safe and effective way for ending unwanted pregnancy with drugs. With greater availability of these promising drugs, pharmacists which are the first-line healthcare providers have an increasingly important role to play in delivering accurate information about them and ensuring the increased access to such methods.
Purpose: This study aims to present the influence and role of Pharmacists.
Materials and Methods: This review article contains summarized information from available literature sources in national and international journals about the role of the pharmacist in advising patients on medical abortion drugs intake.
Results: Pharmacists may be reluctant about informing and counseling women about medical abortion. The variety of reasons include: worry about the health risks; ethical, moral, and religious considerations; fear of backlash from anti-abortion groups; and perceptions that physicians, rather than pharmacy workers, should provide such information. Sometimes professionals who were willing to provide information and dispence the medicines often gave patients incorrect or incomplete information about the route of administration, dosages, side effects, and gestational limits for medications used for medical abortion. Detailing visits included talking with pharmacists about evidence-based information. Individualized outreach visits did affect provider behaviors, especially the prescribing. Training of pharmacists using promotional materials and educational courses are gaining success, but without strong evidence for longer-term impact.
Conclusion: Pharmacists' knowledge about medical abortion is limited. Many of them are willing to provide something to help a woman with an unwanted pregnancy but do not feel confident to recommend this way of ending unwanted pregnancy. Women rarely seek help and medicines information from pharmacists. There is unmet need of approaches that successfully improve pharmacists' ability and willingness to provide accurate information about medical abortion.

P.068

The role of clinical experience in reducing surgical intervention of early medical abortion: a prospective cohort study from an outpatient gynecological clinic

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Objective: The decision of surgical intervention of early medical abortion is often a clinical estimate not based on objective, validated measures. We hypothesized clinical experience with early medical abortion to be the main influencer on the decision to surgically intervene. We therefore aimed to assess the association between risk of surgical intervention of early medical abortion and calendar time in an outpatient, one-physician-only gynaecological clinic.
Methods: Prospective cohort study of all medical abortions induced at a gestational age < 6 3 days in a Danish outpatient gynecological clinic with a single physician deciding the need for surgical intervention through the years 2008-2012. All medical abortions were home-based, induced with 600 mg Mifepristone and 0.6 mg Misoprostol, and all women were offered ultrasound control scans. All medical abortions were fully followed up for eight weeks. Information on gestational age, maternal age, previous deliveries, and history of induced abortion was obtained. The proportion of surgical intervention per calendar year was assessed. A multiple logistic regression model containing all extracted information provided adjusted odds ratio (OR) with 95 % confidence interval (CI) of the influence of calendar time on the risk of surgical intervention.

Results: A total of 1373 early medical abortions were included. Of these, 76 (5.5 %) were surgically intervened. The proportion of surgical intervention decreased from 8.5 % in 2008 to 3.4 % in 2012. The adjusted OR of surgical intervention was 0.79 (0.66-0.94) for calendar time, p=0.006.
Conclusion: The risk of surgical intervention decreased over time, independent of changes in risk factors such as gestational age, maternal age, and reproductive history. There seems to be an important learning curve for the handling of early medical abortions.

P.069

Experiences with MToP from day 50 to 63 of gestation at a Swiss University Women's Hospital

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Introduction: Since 2015 medical termination of pregnancy (MToP) up to 63 days of pregnancy has been performed at the University Women's Hospital Basel. Women between 50 and 63 days p.m. receive 200 mg mifepristone p.o. on day 1 and 800 micg misoprostol vaginally on day 3. As the majority of women is not observed after administration of misoprostol and experiences abortion at home, we considered a concomitant monitoring of the effectiveness of the procedure and of patients' perception and acceptance as reasonable.
Methods: For all patients opting for MToP at our University Women's Hospital from January 2015 to March 2018 the following data were collected: age, parity, MToP in medical history, success of the MToP, patient perception of pain and intensity of bleeding. Data were analysed by means of descriptive statistics.
Results: Of 95 MToP performed between 50 and 63 days p.m. 88 were successful with no further measures necessary. One of the patients had to undergo a curettage due to heavy bleeding. 56 of them were nulliparous. Of the 95 patients, 17 of them have had one or more abortion/s. In terms of the intensity of bleeding, 53 out of 95 women considered it as strong as expected, for 35 women it was stronger and for 7 weaker than expected. 40 out of 95 women perceived the pain as strong as expected, for 40 pain was stronger and for 15 less strong than expected.
Conclusions: The scheme for MToP from day 50 to 63 of pregnancy used at our clinic was effective with a success rate of 93% and with a low risk of haemodynamically relevant blood loss. As we found, that a large proportion of patients had underestimated both the intensity of bleeding, as well as the pain associated with MToP, more attention should be paid to these issues prior to MToP.

P.070

The use of mifepristone (RU486) grows slowly even in Italy, although with regional differences.

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Mifepristone (RU486) was introduced in Italy in 2010 after 10 years of political hostility. According to the government's annual report in 2016, the latest data available, mifepristone was used in 17% of all abortions, first and second trimester, with a slight increase compared to 16.4 % in 2015 and 14% in 2014.

The figure varies widely by region. In the north it is 19.8%, in the center 18.4% and in the south 12.2%. However, there are regions with higher percentages such as Liguria (43.0%), Piemonte (38.3%), Emilia-Romagna (28.3%), Toscana (25.0%), Puglia (21.9%) and Lazio (19.1%). A positive example is the S.Anna Hospital in Turin (Piemonte), where in 2017 the mifepristone rose to over 50% of the 3,065 abortions performed and 47.5% of those in first trimester (1336 medical and 1475 surgical). It is useful to remember that in Italy abortions are performed only in hospitals and only in public hospitals with few exceptions in authorized private hospitals. Despite the political controversies and the organizational difficulties medical abortion is increasing even in Italy, with very important rate in some regions and in some hospital.

Pain and Risk Management

P.071

Experience and management of pain in medical abortion up to 9 weeks of amenorrhea in clinical practice. RYMMa study

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Objective: Evaluate the experience and management of pain in medical abortion (MA) up to 9WA in current practice.
Material and method: RYMMa is a prospective, longitudinal, non-interventional study conducted in 23 French centers performing MA up to 9 WA in hospital with a 600mg dose of mifepristone. Primary objective: evaluate the success rate of MA before 7WA and between 7 and 9WA. Secondary objectives (presented hereafter) included the evaluation of pain and analgesic prescriptions in the MA process.
Results: Between November 2015 and May 2016, 893 patients were included. A prophylactic analgesic treatment was prescribed to 657 patients (74%) and was actually taken by 398 of them (61%). It was a step 1 analgesic in 66% of cases (only 244 of the 588 patients who actually took it: 41%) and a step 2 in 31% of cases (effective intake 258/272: 95 %). An analgesic treatment was carried out in 349 patients (46.9%), of whom 174 (50%) had already benefited from a prophylactic treatment. The distributions of prophylactic and curative treatments were equivalent regardless of the pregnancy term (before or after 7WA). Of the 740 patients evaluated, 94 (12.7%) reported no pain, 296 (40.0%) had mild pain, 262 (35.4%) had moderate pain, 79 (10.7%) had severe pain, and 9 (1.2%) had extreme pain. There was no difference before and after 7 WA.
Conclusion: Prophylactic analgesic treatment was prescribed to about 3/4 of patients, but was effectively taken in less than 2/3 of the cases. In the RYMMa study, a difference in the observance of prescribed prophylactic analgesics intake according to their step, ranging from 41% for step 1 to 95% for step 2, was reported. The experience of the procedure seemed acceptable. There was no difference in experience and management according to the term of MA.

P.072

Self-assessed versus declared pain-evaluation during surgical abortion in MYA study

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Objective: Compare self-assessed and declared during consultation pain-evaluation before, during and after surgical termination of pregnancy.
Methods: MYA was a longitudinal, prospective, multicenter, non-interventional study conducted between December 2013 and July 2014 by 36 French private or public hospitals, aiming to observe current practices in surgical abortion up to 14WA. Out of 542 included patients, 233 completed a self-assessment questionnaire concerning pain evaluation after potential cervical preparation and prior to surgical abortion, as well as per- and postoperatively. These results were compared to those collected by the gynecologists from the same 233 patients during the consultation.
Results: According to the questionnaire, 37%, 39% and 62% of the patients experienced pain respectively pre-, per- and postoperatively. However, high level of discrepancy was observed between the data collected during the consultation and those reported further in the self-assessment questionnaire. Indeed, 47%, 35% and 38% of patients who declared experience pain in the questionnaire (respectively pre-, per- and postoperatively) told the opposite to their physician during the consultation. Conversely, 10%, 43% and 15% told their gynecologist having pain, but did not report it in the questionnaire. Overall the consistency rate between self-reported data and those collected during the consultation was only of 67%.
Conclusion: In the MYA study, exploring surgical abortion practices in France, high level of discrepancy was observed between self-assessed and declared during consultation pain evaluation, consistency rate being 67%. Several explanations may be suggested to explain this fact. This issue must be further investigated in order to improve pain management during surgical abortion.

P.073

Accuracy of a Point of Care Test for quantifying HCG in the management of pregnancy of unknown location in an abortion service

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Introduction: Women may seek a termination of pregnancy (TOP) at gestations when there is no visible intrauterine pregnancy on ultrasound. Clinical protocols for Pregnancy of Unknown Location (PUL) require measurement of serum human Chorionic gonadotrophin (hCG), however this can lead to delay in care and incur costs of couriering samples to the lab.
AIms and Objectives: Our aim was to determine whether a Point of Care (POC) test could replace laboratory serum hCG in PUL. Our objective was to determine the correlation between a POC test with laboratory serum hCG.
Methods: Between Dec 2016 and Dec 2017, women who presented to our TOP service with a PUL, had a blood or urine POC test and laboratory serum hCG. The POC machine (VEDA LAB easy reader, Quadratech diagnostics UK) provides a discrete value below 1000 IU hCG and above this gives a range result. Spearman's rank correlation coefficients were calculated for POC and serum hCG results.

Results: 118 women presented with PUL, of which 70 women had a POC test on blood (n=49) or 21 urine (n=21) and a corresponding serum hCG. Spearman coefficient for blood POC was r2 = 0.94; urine r2 = 0.84. The POC accurately identified hCG < 1 000 IU in 78.9% of cases (30/38) for blood and 84.2% of cases (16/19) for urine and correctly identified hCG ≥ 1000 in 92.3% of cases (12/13 blood and urine).
Conclusion: Blood and urine POC test had a strong overall correlation with serum hCG. However the proportion of POC tests that failed to correctly measure hCG at levels < 1000, coupled with an inability to give a discreet value above 1000 IU hCG limits its usefulness in the management of women with PUL.

Second Trimester and More

P.074

Intrafetal injection of lidocaine to induce fetal demise

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Objective: We sought to evaluate the efficacy of lidocaine to induce fetal demise, comparing intracardiac placement to other intrafetal locations.
Methods: We reviewed the charts of all patients undergoing 1% lidocaine injection at the DuPont Clinic, Washington, DC, from June 1, 2017 through April 13, 2018. The volume of 1% lidocaine, location of injection, success, and patient characteristics were recorded.
Results: We identified 63 patients with 64 fetuses, with a median gestational age of 26 weeks (range 22, 31 weeks) and 3 with cardiac anomalies. The median volume was 20 mL (min 20, max 40). Of the 35 transvaginal intrafetal injections, 22 (63%) resulted in fetal demise. Of the 6 below 24 weeks, all (100%) were successful. We identified 42 transabdominal intracardiac injections, of which 13 followed unsuccessful transvaginal injection. Intracardiac injection resulted immediate fetal demise in all cases.
Conclusions: Intracardiac lidocaine is a highly effective agent to achieve fetal demise when indicated. The efficacy of transvaginal intrafetal injection appears to decrease with gestational age with this fixed dose. Additional research is needed to compare efficacy of intrafetal injection by location.

P.075

Missed mid trimester unruptured Tubal ectopic pregnancy: A challenging case

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Background: Ectopic pregnancy is the most serious complication of early pregnancy. Most tubal ectopic pregnancies will rupture in the first trimester. Rarely they can present later and be associated with diagnostic difficulty. We present an unusual case of unruptured mid trimester tubal ectopic pregnancy.
Case: A 28-year-old nulliparous woman presented at 16 weeks gestation to her local hospital with spotting. A diagnosis of missed miscarriage was made after ultrasonography. Two earlier scans at 7 and 12 weeks gestation were interpreted as viable intrauterine pregnancy. Medical management of miscarriage was attempted and she had three failed courses of treatment.

She was referred to our tertiary early pregnancy service for specialist management. A further ultrasound scan was performed with no change to her diagnosis. She was consented for urgent surgical management of miscarriage after cervical preparation with dilapan rods. Ultrasound guided surgical evacuation was attempted. The uterine cavity was found to be empty. A consultant radiologist attended and further on table ultrasonography was performed. A diagnosis of unruptured tubal ectopic pregnancy made and decision for laparotomy. Per operatively the uterus was found to be of normal size and a right-sided unruptured tubal pregnancy was found with no haemoperitoneum. Right salpingectomy was performed. Histopathology confirmed a tubal ectopic. The patient made an uneventful recovery.
Conclusion: Unruptured second trimester tubal ectopic pregnancy is a challenging case to diagnose. A high index of suspicion is needed in cases where repeated attempts at medical management have failed.

P.076

Flexible Mifepristone Misoprostol interval for second trimester medical abortion: A retrospective cohort study

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Objectives: Examine the effect of shortened mifepristone-misoprostol intervals for second trimester medical abortion on total abortion (mifepristone to fetal expulsion) and induction (misoprostol to fetal expulsion) times.
Method: This retrospective cohort study included women who elected for a second trimester medical abortion with mifepristone and misoprostol at Stanford University Medical Center. Women presenting with rupture of membranes, cervical insufficiency, or preeclampsia were excluded. Times of mifepristone administration, misoprostol administration, and fetal expulsion, as well as parity and gestational age (GA) were abstracted from the medical record. Mifepristone-misoprostol intervals were grouped as (A) 12- >24 hours.
Results: Between 01/2008 and 02/2017, we identified 90 women in groups A (n=60), B (n=20), and C (n=10), with a median GA of 22/0 weeks (range 15/0-28/0) and parity of 1 (range 0-5), no differences observed between groups. Median (range) total abortion time in hours between groups were (A) 19 (3-47), (B) 30.5 (16.5-48), (C) 40 (32.5-48) (p Conclusion: This study support previous findings that the mifepristone-misoprostol interval does not significantly influence the induction time but does significantly contribute to the total abortion time. Strict adherence to guidelines may unnecessarily prolong the abortion procedure. It is reasonable for providers to consider flexible mifepristone-misoprostol intervals if it is preferential to the woman or the facility.

Statistics

P.077

Trends in the method and gestational age of abortion in high income countries

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Abortion is a common event in women's lives: in 2010-2014, an estimated 56 million abortions occurred, and nearly eight million occurred in high-income countries. While abortions in high income countries are generally safe, examining the distribution of abortions by gestational age and method is important for understanding women's demand for and access to health services. With the increasing availability of medical abortion in most countries, data on the method of abortion can provide insight about the options women may have to terminate their pregnancies. Gestational age data are also necessary to collect, as the risk of abortion-related morbidity and mortality increases with gestational age, and can highlight barriers in accessing abortion services. Ultimately these data are of use to policy makers and service providers to ensure that women have access to safe and high quality abortion care.
This review provides a cross-national comparison of the gestational age and method of abortion in high income countries, and of trends in these characteristics over time. For 26 high income countries we compiled data for 2016, or the most recent year of available data, and ten years prior, on the gestational age and method of abortions performed. Reasons for potential differences across countries were also explored.
Since 2006, all countries have seen an increase in the proportion of medical abortions, and in the majority of countries medical abortion now accounts for at least half of all abortions. In the last decade there has also been an increase in the proportion of abortions that were obtained at earlier than nine weeks gestation, and in 2016 over two thirds of abortions occurred at less than nine weeks gestation in almost all countries. These findings highlight changes in abortion provision over the past decade, and suggest improvements in women's access to timely care and choice of methods.

P.078

Identifying women most at risk of repeat Termination of Pregnancy: Results of a retrospective multicentre study in the Netherlands in 2015

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Objectives: According to the annual national survey among abortion clinics in the Netherlands approximately 36% of women seeking a Termination Of Pregnancy (TOP) had one or more prior TOPs. This study was performed to assess the characteristics of Dutch women who have had multiple pregnancy terminations and to identify possible risk factors.
Design and methods: This study was set up as an observational, retrospective, multicenter study based on data from 9 Dutch abortion clinics in 2015. During the study multiple topics were queried, including; number of pregnancy terminations, gestation, age, marital status, number of children, motivation for seeking TOP, contraceptive choice prior and after treatment.
Results: Retrospective data from 6878 pregnancy terminations has been obtained for this study. Descriptive analyses of the total cohort show that age ranged between 15 and 51 years of age. All women lived in the Netherlands and the gestational age ranged between 28 and 159 days (mean: 57,8). Women aged between 25 – 35 years old obtained the highest proportion of repeat TOP (53%). Approximately 50% of the study population was single and 59,46% had 1 to 3 children. The most common motivation for seeking a TOP was not wanting any more children (32,32%). Followed by the relationship with the father (30,49%), social economic reasons (22,11%) and education/work (17,49%).
Conclusions: Results of this study show that in the Netherlands single mothers within the age range 25 to 35 years are most likely to seek multiple TOPs. This is equivalent to the trend described in the annual Dutch survey but is contradictive to characteristics presented in repeat TOP studies worldwide.

By identifying these women and by providing extra contraceptive counselling during follow-up, this study suggests that the number of repeat TOPs in the Netherlands can be reduced.

Unsafe or Safe Abortions

P.079

Uterine vascular abnormalities following induced abortion: an observational study

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Objective: Metrorrhagia subsequent to Induced Abortion (IA) is frequent but rarely severe. Visualization of an intrauterine hypervascularization with Doppler sonography identifies a Uterine Vascular Abnormality (UVA). These UVA include arteriovenous malformations (AVM) and hypervascularized trophoblastic retentions (VTR). The aim of our study was to report a series of UVA in a context of IA, diagnostic value of pelvic Doppler sonography, therapeutic treatment and fertility outcome.
Methods: An observational study was carried out from January 2013 to December 2015. The patients were classified in three categories: High-flow AVM, Low-flow AVM and VTR according to the results of the pelvic angio-MRI and the angiography.
Results: The frequency of UVA in our study was of 18/8397 (0.21%) with a frequency of 14/3159 (0.4%) medical abortions and of 4/5238 (0.08%) surgical abortions. The sensitivity and specificity of the pelvic sonography for the diagnosis of AVM were of 100%. The sensitivity, specificity and the predictive values both positive and negative for the diagnosis of AVM in case of UVA were respectively 84.6%, 0%, 68.8% and 0%. A total of 4/4 (100%) high-flow AVM, 5/9 low-flow AVM (55.6%) and 3/5 VTR (60%) required embolization. An expectant management enabled a spontaneous regression in 6/18 cases (33%). Four patients were pregnant.
Conclusion: Sonography enabled the diagnosis of UVA in all cases with a low diagnostic value for differentiating AVM from VTR in the case of UVA. Sonography is relevant to diagnose UVA subsequent to IA. There is no impact on subsequent fertility in case of embolization following an IA.

P.080

State- and health system- level variation in utilization of in-facility abortion services in Mexico 2000-2016

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Objective: We describe utilization of public sector abortion services in Mexico, 2000-2016.
Methods: We used hospital discharge and primary care clinic data from the Ministry of Health (MOH), serving the poor and informal sector workers, and the ISSSTE/IMSS serving private workers and formal employees, 2000-2016. We calculated the Abortion Services Utilization Rate (ASUR), or number of events (induced, spontaneous and/or unspecified: ICD codes O00-O08) per 1,000 women 15-44 years old. We compared the proportion of all abortion services provided by each sector and described their utilizations by state.

Results: Over the period, utilization of public abortion services increased from 169,178 in 2000 up to a maximum of 232,828 in 2012, and down to 212,077 in 2016, for a total of 3,414,051 events. Overall in the period, 7.3 women per 1,000 women 15-44 utilized abortion services, from a maximum of 12.5 in Mexico City and 9.0 in Aguascalientes down to a minimum of 5 in State of Mexico. ASUR was 6.8 in 2000, peaked at 8.1 in 2011 and plateaued to 7.1 in 2016. In Mexico City, initial ASUR was 8.8; utilization increased steadily over time, and then sharply after legalization to a high of 17 in 2011, then flattened and reached 14.5 in 2016. Relative contribution of different health sectors changed over time; MOH accounted for 44.9% of all abortions in 2000 and 64.7% in 2016, and the ISSSTE/IMSS services declined from 42% to 26.7% of all abortions. MOH primary care services increased from 2.1% in 2004 up to 8.5% in 2016, due largely to legal abortion program in Mexico City.
Conclusions: Utilization of public abortion services increased over time in Mexico but has recently plateaued. The MOH provides an increasingly greater proportion of services than other public sectors, including first trimester procedures on demands in Mexico City.

P.081

Scale and quality of medical abortion provision by pharmacies and drug sellers in low- and middle-income countries: a systematic review

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Objectives: Pharmacies are an important source of health care in low and middle income countries, including for access to medical abortion (MA). We conducted a systematic review to assess 1) the level and quality of pharmacy and drug shop provision of medical abortion and 2) interventions to improve quality of provision.
Methods: We used standardized terms to search six databases for peer-reviewed and grey literature. We double-extracted data using a standardized template, and double-graded studies for methodological quality.
Results: We identified 22 studies from 16 countries reporting on level and quality of MA provision through pharmacies and drug sellers, and three intervention studies. Despite widespread awareness and provision of MA drugs, even in legally restricted contexts, most studies found that pharmacy workers and drug sellers had poor knowledge of effective regimens. Information provided by individuals working in pharmacies and drug shops was poor, with many recommending ineffective drugs, few advising an effective regimen, and few giving information on potential complications and what to do if they occur. Evidence on interventions to improve pharmacy provision of MA was limited and generally low quality, but indicated that training, with some form of follow up, can improve knowledge. One study also suggested information provision through call centres, but not pharmaceutical one-to-one visits, may be effective in improving knowledge.
Conclusions: Pharmacies can expand access to medications for MA, but they do not always provide the right products or effective regimens, and the quality of their knowledge and information provision is often poor. Leveraging the benefits of pharmacies, such as their perceived accessibility, affordability, and confidentiality, has potential to reduce the harm caused by unsafe abortion. More innovative interventions are needed to build the evidence base on what works to improve provision through pharmacy workers and drug sellers and to increase women's access to information.

P.082

Understanding the role of community-based mobilizers in access to post-abortion care among women in a sub-Saharan African country

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Objectives: Restrictive and unclear abortion policies, fears of legal consequences, misinformation, judgment and stigma can prevent women from seeking safe abortion services. Community-based mobilizers (CBMs) work in their communities to increase access to accurate information about safe abortion and post-abortion care (PAC), and provide referrals. This study aimed to assess barriers and facilitators to PAC among women who were referred by CBMs and those who reached clinics through other sources.
Methods: Between March and September 2017, we conducted surveys with 275 women who obtained PAC at six participating clinics representing diverse geographical areas in a sub-Saharan African country. 134 women were referred by a CBM and 141 reached care through other sources.
Results: The majority (82%) of participants were first-time clients. Clients referred by CBMs were younger (72% of CBM-referred clients were under 25 years, compared to 47% of non-CBM referred clients). Referred clients were more likely to have experienced trouble getting money to pay for services (82% of CBM-referred clients vs. 59% of non-CBM referred clients). 45% of CBM-referred clients and 38% of non- CBM referred clients reported that they wished they could have accessed care earlier. The majority of participants (72% in both arms) reported that they felt supported by someone before their PAC service. Among those who were CBM-referred, the majority of clients reported that the CBM who referred them was trustworthy (88%), supportive (93%), and helpful in their access to PAC (93%).
Conclusions: Women who were referred by a CBM had similar experiences as women who were not referred. Women who were referred by a CBM reported positive experiences with the mobiliser. Expanding community mobilisation programs to increase awareness of services may increase women's access to PAC in restrictive settings for women who otherwise would not be able to access care.

P.083

Building awareness of safe services for abortion care in a stigmatized environment: Development and evaluation of a marketing campaign by Marie Stopes Ghana

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Objectives: Worldwide, 25 million unsafe abortions occurred annually between 2010-2014. One reason for this is a lack of reliable information about rights, entitlements and options, since abortion is highly stigmatised and legally restricted in many countries. Abortion stigma can make it difficult for abortion providers to actively improve awareness of their services without fear of backlash from community and institutional actors. The aim of this program was to design and evaluate a marketing campaign to raise awareness of safe abortion options in Ghana through mass media in a socially acceptable way.

Methods: The campaign was designed following a literature review on abortion access in Ghana, which identified key messages and priority audiences. Campaign messages and materials were pilot tested. The campaign will be evaluated using routine service data. Interrupted time series analysis will be used to assess the effect of the campaign on the number of contacts to the Marie Call hotline, and number of women accessing safe abortion services from Marie Stopes Ghana's delivery channels. The socio-demographic characteristics of clients and their sources of marketing information will also be assessed.
Results: A multi-pronged campaign called "Time to Talk" was developed, using radio, billboards, social media and community events, and spearheaded by a celebrity ambassador. The campaign used sensitive, legally appropriate and subtle language and imagery to promote the Marie Call hotline as a trusted and confidential source of pregnancy advice, including both pregnancy prevention and support for women to understand their options after an unexpected test result. The campaign was launched in April 2018, and its effect will be analysed in July 2018, with full results available by September 2018.
Conclusions: Evidence-based strategies to improve awareness of safe abortion options are needed, and this evaluation will provide insight into the acceptability and effectiveness of a multi-pronged marketing campaign.

P.084

Barriers to seeking safe menstrual regulation procedures in Bangladesh

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Objectives: Abortions are restricted in Bangladesh, and menstrual regulation (MR) exists as an approved alternative available free of charge in the public health system. Women commonly seek MR outside health facilities, yet who is most at risk, and how their social context and community influence their decisions is not fully clear. We examined the barriers women face the context of attempting to terminate a pregnancy, and how these affected treatment-seeking and decision-making.
Methods: In 2015, we conducted 43 in-depth interviews with women in urban and rural Dhaka division who had had MR procedures outside health facilities using a multi-pronged recruitment strategy. We recruited women through contacts in the community and later asked the women we interviewed to refer other women to us. We also conducted formal and informal interviews with stakeholders, and made observations of formal and informal health facilities. We took a social constructivist approach to analysis and used iterative thematic coding to identify emergent themes and categories.
Results: Seeking care for MR was difficult for women, particularly from health facilities. Women spoke of cultural barriers restricting their movements, which made it difficult to physically access health facilities, especially if they sought care without their family's support. Women also reported difficulties acquiring knowledge on reproductive health, and said they did not know where to go for safe services. Women received most support from other women in their communities as well as their maternal families.
Conclusion: We found that providing free and legal MR is not enough to ensure women have access to safe services. Women face barriers in virtually all aspects of seeking care. In order to make MR more accessible at the community level, we must consider not only individual actions and decisions but the wider cultural context in which women are seeking care.

P.085

Providers face barriers too: Maximizing Healthcare Provider Performance (MAX) Program efforts to increase access to safe abortion in Kenya and South Africa

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Objectives: Women face numerous barriers to accessing abortion services, especially in resource-limited contexts; however, providers also experience challenges. Providers may face stigma, have limited training, need access to stock, and work in clinics with limited resources, space, and equipment. To improve access to safe abortion, the Maximizing Healthcare Provider Performance (MAX) program employed an innovative strategy to partner with providers, assessing needs, and implementing a series of tailored interventions to address barriers.
Methods: From January 2013 to June 2017, MAX field representatives collected monthly data on abortion services from providers in the private sector in Kenya (n=164 over 42 months) and the public sector in South Africa (n=313 over 50 months). We examined frequently reported barriers to delivering abortion services as well as intervention activities associated with statistically significant changes in provider delivery of abortion services over time.
Results: Providers reported numerous barriers to the delivery of abortion services, including the availability of supplies; facility and infrastructure barriers (e.g. staffing, clinic conditions, referral processes); provider skills (e.g. training, provider-client communication); community awareness of services; and importantly, harassment or marginalization. MAX interventions addressed these barriers in unique ways, specific to country contexts. In Kenya, providers exercised greater autonomy and individualized attention from MAX field reps was often sufficient to address barriers and motivate change. In South Africa, providers had more limited control over their environments, so MAX worked with administrators to create sustainable improvements. Across countries, in addition to the need for skills training and increased client awareness, the provision of social support and the creation of an enabling environment were crucial to improving abortion services.
Conclusions: Given the challenges associated with increasing access to safe abortion globally, providers must be treated as partners. This requires comprehensive solutions that address barriers and support providers in the delivery of services, especially in stigmatized environments.

P.086

Supporting abortion care providers to resolve barriers in stigmatized environments: Lessons learned from the MAX Program in the Kenyan private sector and the South African public sector

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Objectives: Health care providers confront restrictive barriers in the provision of quality abortion care.

In Kenya, private-sector abortion providers are subject to violence and harassment from authorities and from their communities. In South Africa, abortion providers working in the public health system face marginalization that results in lack of access to promotion and incentives, and burnout due to inadequate staffing and resources. The Maximizing Health Care Provider Performance (MAX) program was initiated by WCG as a holistic approach to support health care providers and improve comprehensive abortion care (CAC). MAX field representatives visited participating providers on a monthly basis to jointly identify and address barriers to the provision of CAC.
Methods: From January 2013 to June 2017, field representatives collected monthly data on abortion services from providers (in Kenya, n=164 over 42 months; in South Africa, n=313 over 50 months). We examined frequently reported barriers to delivering abortion services as well as intervention activities associated with statistically significant changes in delivery of CAC services over time.
Results: One of the most surprising results was the importance of social and emotional support to improvements in CAC service delivery. MAX's focus on relationship building with providers in the context of stigmatized environments was central to effectively engaging, recruiting, and motivating providers to continue to provide CAC services despite challenges. In both countries, social support interventions provided by field reps were associated with at least a 20% provider improvement in one or more program outcomes. In Kenya, interventions specifically to prevent or address harassment/stigma were associated with a 50% or greater increase in outcomes.
Conclusions: In highly stigmatized environments, abortion care providers need extra support to help mitigate the risks they incur in offering CAC services. Similar programs should consider adding elements of social support and relationship-building to program activities to further enhance program outcomes.

P.087

Low rate of body mass index, As a risk factor of spontaneous abortion

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Objective :to study the influence of inadequate body mass in pregnant females on spontaneous miscarriage.
Design /method : an epidemiological complete survey with a follow-up. Routine measurements of body mass and height in 780 women aged 17-36 years with less than 7 weeks gestation. The nutricional state was estimated by the Quetle Index (QI).
Results : the total number of spontaneous abortions was 45 (5,8 %)cases.Their lowest rate was detected with a QI of 21-22,9 kg/m2 (4 cases among 192 pregnant females,or 2,1 %). There were 29 (7,7 %) miscarriages among 375 pregnant female. 5,6% spontaneous abortions occurred in 213 pregnant females with a QI of 22,9 kg/m2 .
Conclusion: this study confirms previous studies that indicated a small positive association between inadequate body mass and spontaneous abortions risk. Our results suggest that small body mass is a stronger risk factor for early pregnancy losses.The optimum QI range was 21-22,9 kg/m2.