The 14th FIAPAC Conference

Fertility control into the hands of women

ABSTRACTS

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Abbreviations

PS: Plenary session
CS: Concurrent session
LS: Lunch session
FC: Free communication
PP: Poster presentation
P: Other posters

Plenary sessions

PS1.1

Will the past become the future?: the interaction of technology and politics

Winikoff Beverly, Gynuity Health Projects, New York City; Mailman School of Public Health, Columbia University, Population and Family Health, New York, USA

Humans have always been curious about the processes of creating new members of the species --- sometimes with awe, wonder and celebration and other times with secrecy, dread, and attempts or thwart birth. In either case, there was not much science or technology to use to assure either outcome safely in most of human history. With more scientific understanding, specific technologies evolved -- but their use has always been subject to political, religious, and class issues -- determining who had access to "scientific advances." As we look back on the past, we see that the great barriers of lack of good science and absence of appropriate technology are not the only pre-requisites for the development of and accessibility to important ways to make abortion safe and available. The past teaches us that advances in reproductive health must be surrounded by social and political environments that value inclusion, autonomy, and equality.

PS1.2

Losing Control in the Present: Abortion Here, There and Everywhere

Jelinska Kinga, Women Help Women; Abortion Dream Team; Abortion Without Borders, Amsterdam, The Netherlands; Joanna Erdman, Dalhousie University, Schulich School of Law, Halifax, Canada

Abortion has long been about control, a belief in regulated systems of control over the who, how and where of abortion: abortion law to restrict access, abortion law to protect access. Always abortion law and order. Every effort to build medico-legal systems of abortion care and to lock people within them. Every effort to create that Roe v. Wade moment between a provider and their patient when crime magically turns into care. But abortion today is OUT of CONTROL.
We are in a revolutionary moment. A moment that has inspired and united activists in a spirit of revolt against the control ethic of our field and the traditions of power and privilege that sustain it. We have abortion networks not systems. People not policies. Pills not procedures. We have abortion practice that travels and evolves from place to place and time to time. Abortion in-clinic, at-home, online and in-transit. A multiverse of abortion. We have the many experiences of abortion, not its singular management. These are experiences both intimate and collective, born of the lives of people, fluid in gender and sexuality. Abortion with pills and the activism around it has always been transnational, defying national borders, while rooted in specific need and local context. In a world defined by territorial control and expansionist conflict, abortion beyond borders is a struggle for freedom and justice. Abortion is not only health care, it is political engagement and agitation, leading some of us not to the courts as advocates, but as defendants of our actions (#IamJustyna). Abortion rights today are not abstract ideals stripped of place and person. Abortion rights are authored by the collective and claimed by a growing chorus of voices. Without rules about right and wrong, every abortion tells its own story.

PS1. 3

The present in settings where abortion is legal: self-managed abortion

Endler Margit, Karolinska Institutet, Department of Women's and Children's Health, Stockholm, Sweden

This presentation will discuss the status of abortion care in an ever-changing legal landscape, where legality does not always signify access but where pragmatism sometimes overwins official policy. It will present an overview of current trends in abortion care in settings where abortion is primarily legal, trends that further de-medicalisation, decentralisation through remote provision, and self-management, as well as the evidence that support these policy changes. It will also discuss women´s motivations for seeking abortion care in the informal sector despite legal prerequisites in the formal sector, and look at the resilience of abortion care services in crisis.

PS1.4

Overcoming obstacles to medical abortion: a new strategy to liberate the abortion pill

Gomperts Rebecca, Women on waves, Amsterdam, The Netherlands, Women on Web, Toronto, Canada

New strategies are needed to challenge the dichotomy between contraception and abortion and advance women's reproductive freedom.
Research into the data of Women on Web and Aid Access shows how the covid pandemic and recent abortion bans in the USA, created barriers to abortion access and that these telemedical abortion services provided a solution. However it is also clear that mifepristone and misoprostol should become available over the counter because even though they are as safe as commonly used painkillers available over the counter, health authorities, doctors and pharmacies act as gatekeepers. Besides being "the abortion pill", Mifepristone, an anti-progesterone, is an extremely effective morning-after pill and holds great promise as a weekly on-demand contraceptive without the adverse effects of existing contraception (OC).
There has not been any significant improvement or innovation in oral OC since the 1950s. Yet OC is far from ideal; it requires daily usage, almost half of women report method dissatisfaction and it poses significant side effects, including increased risk of thrombosis, depression and breast cancer . 46% of women discontinue taking OC within three years because of method dissatisfaction. Fully meeting the needs for sexual and reproductive health care would result in immense health gains, including a reduction of approximately two-thirds of unintended pregnancies, unsafe abortions and maternal deaths, while improving health and socio-economic outcomes for mothers and children. As a non-estrogen and non-progestogen contraceptive, mifepristone can also be used by women with a history or genetic disposition of breast cancer.
Widely available, Mifepristone 50 mg can fundamentally change the way women all over the world will be able to control their fertility. It will allow them to move flexibly between the medicine's different indications as weekly contraceptive, as an on- demand method used before or after sexual intercourse or as an early medical abortion method, depending on their life circumstances. By developing mifepristone as an on-demand contraceptive, it can also potentially finally become available over the counter, in line with its safety profile.

PS2.1 (not available)

PS2.2

Improving access to emergency contraception

Christina Puig Borràs, European Consortium For Emergency Contraception, Barcelona, Spain

Access to emergency contraception (EC) has improved significantly in Europe in the past 10 years. More EC methods are available and have become more accessible. Since 2011 the European Consortium for Emergency Contraception (ECEC) follows the events and strategies that brought EC closer to the hands of women:
- Malta was the only European Union (EU) country without EC products registered, until in June 2016 a women's rights organization filed a judicial protest to reverse this situation.
- In the United Kingdom, the average retail cost of EC pills was one of the highest in Europe; a coalition of organizations and individuals, undertook a campaign that resulted in a significant reduction of the price of LNG EC pills.
- In the EU, a pharmaceutical company triggered the biggest change in EC accessibility. UPA ECPs were registered at the centralized level (through the European Medicines Agency (EMA). When the EMA approved their switch, this type of EC became available over the counter (OTC) in all (at the time) 28 countries, overnight. Other companies requested the switch of LNG EC pills in countries with long and strong opposition to OTC, such as Croatia, Germany and Italy.
- In the United States, the American Society for Emergency Contraception and students' organizations collaborate to set EC vending machines in college campuses.
Despite this progress, barriers to EC access remain:
- In settings where both UPA and LNG EC pills are available without prescription but kept behind the counter, pharmacists act as gatekeeps. Conscientious objection is a problem in parts of Italy, Spain, Malta.
- The cost of EC pills is also an important barrier in Eastern Europe, the USA or Japan.
- Never-ending proliferation of myths about EC (concerns on future fertility, extreme side effects, harm of repeated use), deter women to resource to EC when in need.
- In Honduras, Peru, or Philippines, some still consider that EC may have an effect on implantation. The outdated description of LNG ECP's mechanism of action in the USA Federal Drug Administration (FDA) label of EC products fuels this problem. Labels of many European LNG EC products have been updated.
Conclusions: Advancing access to emergency contraception requires the global collaboration of a wide range of players, including scientific societies, women's groups, reproductive rights advocates, EC manufacturers and distributors, policy makers, regulatory agencies, students organizations, EC advocacy group, journalists, and more.

PS2.3 (not available)

PS3.1 (not available)

PS3.2

Innovation is Vital(a) - opportunities and challenges of co-created digital platforms for self-managed medical abortion in humanitarian settings

Gill Roopan, Vitala Global Foundation, Toronto, Canada, University of Toronto, Obstetrics and Gynaecology, Toronto, Canada; Tam-Saadi Genevieve, Vitala Global Foundation, New York, USA

Background:
In humanitarian/fragile settings that face restrictive abortion laws, digital health interventions can be valuable in providing evidence-based information and emotional support for individuals seeking abortion care. Feminist accompaniment has been shown to improve the quality of a person's abortion experience, however since the Covid pandemic, the need for virtual tools has become more apparent to compliment these efforts. Vitala Global has developed digital solutions to support people living in humanitarian contexts. Aya Contigo is an evidence-based mobile application, which was co-created with Venezuelan women and girls to provide accompaniment and emotional support as they self-manage their medical abortions. A human-centered design and community-led process was utilized to co-design, co-implement and co-sustain the digital platform. Evidence highlighting this process is necessary to add the evidence base of innovative models of care for self-managed medical abortion in humanitarian contexts.
Objective(s): 1) Discuss the importance of context-adapted and community-led co-development of digital health solutions to facilitate self-management of abortion and contraception care in challenging contexts
2) Present an example of the development of human and community-centered digital tools for self-management of medication abortion in humanitarian context
3) Highlight learnings through digital self-managed care tools with emphasis on self and community care to navigate complex contexts
Methods: A 3-phase human-centered, mixed-methods design process was utilized to co-design and implement a digital platform to support self-managed medical abortion care in Venezuela. Phase 1 included a mixed-methods formative research phase using a social media survey and remote semi-structured individual interviews. Phase 2 was the co-creation and user testing and development phase that was done remotely with stakeholders and people who had an abortion previously. Phase 3 included a mixed-methods process evaluation to determine feasibility and acceptability of the digital platform.
Results: Since the launch of Aya Contigo in Venezuela, 600+ Venezuelans have engaged with the platform and 200+ have been supported by the virtual care team. Movement building efforts have led to the engagement of 30 local Venezuelan organizations and involvement in two major advocacy movements for legalizing abortion in Venezuela. User feedback has centered around the emotional support, importance of evidence-based and clear information and the feelings of empowerment to self-manage their care.
Conclusions: Innovations such as Aya Contigo demonstrate the importance of co-led and co-created design processes from conception to scale to improve access and the quality of safe, supported self-managed medical abortions for those living in humanitarian and fragile settings.

PS3.3

Taking action against abortion-related stigma affecting clinicians

Kavanagh Jayne, RCOG, Centre for Women's Global Health, London, UK

Drawing on data from a global study exploring the experiences of stigma amongst healthcare professionals providing abortion care conducted by the Royal College of Obstetricians and Gynaecologist's Making Abortion Safe programme in 2021/22, this presentation will consider how to support clinicians who provide abortion care manage the stigma they experience, as well as outlining education, training and other strategies that might be employed to reduce abortion-related stigma, with a focus on stigma perpetrated by healthcare colleagues.

PS4.1

Do laws shape our practice? Does practice shape our laws?

Sheldon Sally, Bristol University, Law, Bristol, UK

The answer to the first of the questions posed in this title is probably not too surprising. Yes, laws undoubtedly shape clinical practice, sometimes laying down in considerable detail what is permitted and what not. The answer to the second may be less obvious but again the answer is yes: health professionals – particularly doctors – sometimes have exerted considerable influence both on the drafting of new laws, and their interpretation and implementation in practice. Indeed, a detailed study of five decades of the British Abortion Act 1967 suggests that the passage of a new law is only ever a starting point, with a law's meaning then created over time by a range of actors. In the case of the Abortion Act, this cast list has included women who sought medical assistance to end their pregnancies, the health professionals that they encountered, service providers, pro-choice and anti-abortion campaigners, lawyers, judges, politicians and policy makers. In this presentation, I draw on the UK experience to suggest some more general lessons for campaigners and service providers.

PS4.2

Preventing or ending pregnancy? Does it matter? Do we care?

Clare Murphy, British Pregnancy Advisory Service, UK

The prevention of unplanned pregnancy is a key public health goal. Unplanned pregnancy is deemed a problem both in terms of continuing pregnancy given the increasing focus on women being "fit" for pregnancy, but also in terms of abortion which should be prevented wherever possible. Contraception programmes are built around the promotion of the most effective methods, such as the IUD or implant, with user-dependent methods seen as a poor relation. This is on the basis that for any woman who is sexually active but not planning a pregnancy, efficacy must be her greatest concern. There is little acknowledgement that some women may be content to use a less effective method because it suits them and their lifestyle better, and are content to have abortion as a backup if that method fails.
There is also little recognition that hormonal contraception, while safe and well tolerated, has its downsides for some women. Risks of hormonal contraception are consistently and correctly set against the risk of being pregnant. However ideally, we would develop methods that a woman would only use if she missed her period to avoid daily or ongoing use of a method of contraception which she may neither want nor need. Even now, telemedical abortion care in which women can receive medication by post in the comfort and privacy of their own home following a consultation with a

healthcare professional may transform the acceptability and usage of abortion as a method of birth control. While legal frameworks tend to position pregnancy as beginning after implantation not fertilisation, there is little to suggest women themselves see this as marking any particular moment of ethical or practical significance, even if they may feel differently about the embryo/fetus as gestation advances. What does this mean for the provision and development of woman-centred reproductive healthcare services and how should it shape our advocacy?

PS4.3

Stopping the clock on abortion time limits

Furedi Ann, Kent, UK

Abortion laws in most countries have an upper gestational time limit and it is widely assumed that such limits prevent abortions taking place beyond a stage seen as socially and politically acceptable. Sometimes, but not always, there are 'special case' exceptions to a time limit. In the UK, for example, a time limit of 24 weeks exists UNLESS the abortion is carried out to prevent grave permanent injury or death to the woman, or there is evidence to suggest a disabling fetal anomaly.
This paper explores why a legal time limit is assumed to be important and is acceptable even too many advocates of women's choice.
Usually, the politico-legal justification for a time limit is that it differentiates and sets apart pregnancies in which the fetus is viable, which in this context means: capable of existing outside the the womb. However, the capacity for the survival of severely premature infants relies on a large number of social and individual factors that make it impossible to predict with any accuracy for a particular pregnancy. One fetus at 24 weeks may not be exactly like another.
And then there is the question of when the gestational clock begins. Implantation, the legal point at which a woman becomes pregnant, is a process that may begin on one day and complete on another. And in a further complication, the gestation of pregnancy is in many countries counted from the first day of the LMP i.e. even before conception.
Finally, we explore whether gestation confers any moral significance. Is there a moral difference between an abortion at 23 days, 23 weeks or later?

Concurrent sessions

CS2.1

Contragestion

Gemzell-Danielsson Kristina, Karolinska Institutet, Women's and Children's Health, Stockholm, Sweden

Safe and acceptable abortion- and contraceptive methods are prerequisites for reproductive health, for gender equality and for the empowerment of women as well as for the development of society. New methods for contraception include improved methods for emergency contraception and methods with new mechanisms of action as well as additional non contraceptive health benefits. 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 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. Due to their effect on endometrial receptivity and possibility to prevent or disrupt implantation progesterone receptor modulators have also been studied for "contragestion" in the form of "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. This progesterone receptor modulators such as mifepristone if offered in a suitable dosage and mode of delivery provides a model for a woman centred contragestive method with added health benefits and increased reproductive autonomy.

CS2.2

Bridging contraception after emergency contraception

Cameron Sharon, NHS Lothian and University of Edinburgh, Sexual and Reproductive Health, UK

Emergency contraception (EC) can prevent pregnancy following an episode of unprotected sex, but unless women start a regular method of contraception following EC they remain at risk of pregnancy. Clinical guidelines therefore emphasize the importance of starting effective contraception as soon as possible after EC. In an increasing number of settings women now choose to get EC from a community pharmacy but in most settings the pharmacist can only provide barrier contraception like condoms, unless the client has a prescription. This means that women need an appointment usually with a GP or a sexual and reproductive health (SRH) clinic to obtain contraception. Getting an appointment is not always easy and can take time. During this time, an unintended pregnancy can occur.
The progestogen only pill (POP) is an effective contraceptive that most women can safely use, unlike combined hormonal pills. If a pharmacist could give a 'bridging' supply of the POP along with the EC then this would provide temporary effective contraception for women until they get an appointment at a clinic to get their preferred method.
The 'Bridge -it' study was a cluster randomised study from the UK designed to determine if pharmacy provision of a three-month supply of a POP along with the EC, together with a card that helped women an appointment at a local SRH clinic (intervention) would result in more women using

effective contraception four months later, compared to just giving EC alone (control). Bridge it recruited 636 women, to the intervention (316) and control (320) groups and collected information on contraceptive use at four months on 65% of participants. Use of an effective method of contraception was around 20% higher amongst women in the intervention group compared to the controls; a large and clinically important increase. Also, significantly fewer women in the intervention had to use EC again within that time. Very few women made use of the rapid access card to the SRH clinic and most women in both groups obtained further contraception from a GP. Interviews with pharmacists and women confirmed the acceptability of providing POP from the pharmacy and the potential for this to be widely implemented and successfully embedded within routine pharmacy practice. If widely implemented, this simple intervention has potential to prevent more unintended pregnancies for women after EC.

CS2.3

Emergency Contraception: new options in EC

Edelman Alison, Oregon Health & Science University, OB/GYN, Portland USA

Emergency contraception (EC) provides individuals with an additional line of defense against unintended pregnancy following an act of unprotected intercourse. Currently available, orally dosed methods, like levonorgestrel (LNG) and ulitpristal acetate (UPA), are extremely safe with few side effects. They are highly acceptable to users but ongoing barriers exist to availability, cost, and in some cases, the need for a prescription. Additionally, both oral methods have some use characteristics which can be challenging to navigate (LNG EC appears less effective for individuals of higher BMI and UPA EC is impaired with concurrent hormonal contraception initiation). The 380A Copper T intrauterine device (cuIUD) is the most effective method of EC but an individual must interact with the health care system in a timely manner to obtain one. Furthermore, a cuIUD is typically chosen only if an individual wants a cuIUD as an ongoing contraceptive method and the cuIUD is not as popular as the LNG IUD. Recent research helps to bridge the gap in care for those individuals desiring an LNG IUD but also needing EC – it appears safe and effective to provide immediate LNG EC with LNG IUD placement. The body of research is too limited yet to know if a LNG IUD alone is effective as an EC for those at highest risk, mid-cycle.
New EC options and ongoing development of different methods are urgently needed. Development of EC methods is challenging as a novel agent might cross the contraceptive-contragestive threshold which prompts restrictions in research funding. Ultimately expansion of research in this area would also greatly aid in the development of an 'as needed' peri-coital contraceptive method – a method of contraception missing from the current method mix. This presentation will take a closer look at recent developments in EC and those methods in the pipeline.

CS3.1

How can healthcare providers support self-care: Learnings from a Global Care Consortium

Moreno Pabon Diana Carolina, Asociación Profamilia, Bogota, Colombia, Royo Marta, Asociación Profamilia, Bogota, Colombia

With the increasing number of abortions being self-managed using medical abortion pills, either because of their preferences or because of the lack of other options, IPPF recognizes abortion self-care as the right of women and girls to lead their abortion journey, with or without support from health workers. If a woman does choose to involve a health worker in her abortion self-care journey, what role should they play? How can healthcare staff be supported to transition from a position of gatekeeper and provider of abortion services to a role of facilitator and supportive partner in

abortion self-care?
Since 2021, Profamilia has led the general secretariat of Global Care, a global consortium for abortion and reproductive self-care that aims to enable abortion self-care practices. This consortium promotes the design, implementation and knowledge sharing of person-centered care models that respond to different social and legal contexts. As part of this consortium, Profamilia created a community of practice in which 15 organizations from 11 countries around the world exchange experiences, strengthen their knowledge, and share best practices that contribute to finding solutions that facilitate abortion self-care. The community of practice is a space to collaborate with expert organizations in abortion self-care, strengthen the work of health care provider organizations, and advance the self-care agenda globally and locally.
Through the work of the consortium members, we have learned that each context offers specific legal, cultural, and social challenges that can be addressed by drawing on the experiences of other organizations. Similarly, we have understood that health care providers who promote self-care must always have the person's interests at the center, recognizing and promoting the person's agency and autonomy in their decisions. From this premise, the actions that are subsequently implemented will strengthen the self-care ecosystem from the role that they contribute to the health care system.
From the above, we have identified five different roles that a health care provider has in the support of abortion self-care: i) as an information generator; ii) as a medical and social supporter; iii) as a supply distributor; iv) as a promoter of a supportive social ecosystem; and (v) as a change promoter within the health system. Throughout our lecture, we will build upon this identified roles and the ways in which providers are creatively strengthening their role as self-care supporters.

CS3.2

Providing support for abortion self-care: Experiences from Ghana

Manu K.A., Planned Parenthood Association of Ghana (PPAG), Accra, Ghana

Background: In Ghana, the government’s emergency support to the health sector during the Covid-19 pandemic did not include any special consideration for abortion care. This resulted in low utilization of abortion services at physical health facilities across the country. Stigma and discrimination, and high cost of services have also remained some of the key barriers to accessing abortion care in health facilities. In response, the Planned Parenthood Association of Ghana has designed an intervention to improve access to abortion care via self-care innovations.
Method: PPAG adopted human-centred design in the conceptualization and development of the intervention. The outcomes reflect the principles of learning and sustainability in the organisation’s approach to intervention development. The outcomes presented are from performance statistics, as well as engagement with the project team and key stakeholders; covering January 2021 to June 2022.
Results: The self-care intervention designed is an integrated system, that brings together community cadres (youth volunteers, community leaders, and pharmacies), service providers (from PPAG, and public and private facilities), and contact centre agents to provide quality, responsive, and comprehensive sexual and reproductive health information and services. This system allows users to access abortion services in diverse ways including using a helpline to access the full package of services remotely, or visiting pharmacies and community volunteers to receive care and support.
Since the inception of this intervention, 690 women and girls have received quality self-care services; with only 8 minor complications recorded (a complication rate of 98%). These complications have been resolved successfully at the PPAG clinic without external tertiary support. Client feedback reports a 93% satisfaction rate with self-care options.
As of June 2022, more than 80% of PPAG’s facilities had reported an overwhelming increase in preference for self-care options over in-facility care. Service providers report a significant reduction in caseload at the facility for medical abortion clients.

Conclusions: Self-care has proven to be a viable option to improve access to abortion services for women and girls. The use of digital platforms has been effective, allowing for direct and discreet contact between clients and providers. This emphasizes the need to scale the use of digital solutions in self-care delivery. Community-level options such as pharmacies and community-based volunteers are sustainable, and an effective alternative to digital solutions. More capacity building is required for community cadres to improve their knowledge and skills in abortion care.

CS3.3

Self-care in a digital landscape: supporting online and offline journeys in abortion Care

Crossett Claire, Women First Digital, Chicago, USA

The digital revolution is transforming how more than 4.95 billion global internet users access sexual and reproductive healthcare. As digital penetration spreads further and deeper into markets worldwide, women and young people account for a critical demographic of new online users who are turning to the internet as a first touchpoint for information, including guidance about sexual health and abortion. This increasing use of technology provides a unique opportunity to reach vulnerable populations who are unable to access abortion care within traditional healthcare systems, including those burdened by geography, high cost, stigma, lack of trained providers, or legal restrictions. Women First Digital (WFD) is an eHealth social enterprise that leverages the power of the digital revolution by reaching women directly on their handheld devices. WFD is helping to make access to abortion care more universal through its suite of technologies, offering demedicalized abortion information and customized resources in over 30 languages, including resources designed to support the spectrum of abortion self-care. In addition, WFD fosters online communities where users can share information, obtain online counseling or referrals, and self-determine pathways to services and products. WFD platforms include consumer-facing, mobile-first websites; new technologies, like artificially intelligent (AI) chatbots and provider referral databases; and targeted on-the-ground presence in select countries. The team also invests heavily in search engine optimization, regional marketing strategies, and local partnership building. In sum, WFD minimizes barriers to care by reaching audiences through digital channels and helps equip women with information and resources to self-actualize decisions around their sexual and reproductive health. Between our launch in February 2015 and June 2022, WFD has hosted 20 million sessions with users from 180 countries who visit our websites to obtain information, referrals, and support. WFD has also provided 100,000 personalized abortion counseling sessions to users worldwide, made over 22,000 referrals to on-the-ground providers, and facilitated an additional 125,000 automated conversations through its AI bot.

CS4.1 (not available)

CS4.2 (not available)

CS4.3 (not available)

CS5.1

Anti-D: when is it required

Lord Jonathan, MSI Reproductive Choices, London, UK, Royal Cornwall Hospital NHS Trust, Obstetrics & Gynaecology, Truro, UK

Although the value of anti- D prophylaxis in routine antenatal care in women who are rhesus (RhD) negative is evidence-based, its role in first- trimester abortion and miscarriage management is not. National guidelines are inconsistent and have been based on observational studies from over 40 years ago when practices were quite different.
The need for testing RhD status and administering anti-D acts as a barrier to implementing patient-centred pathways such as telemedicine or community-delivered surgical services. When in 2019 the UK's NICE guidelines recommended against the use of anti-D in early medical abortion, providers immediately changed their practice. This facilitated the widespread introduction of telemedicine pathways in response to the COVID pandemic. The new WHO guidelines have reinforced this advice and go further in including gestation to 12 weeks and surgical abortions.
This session will review the evidence and how practice is changing. The aim is to give clinicians and policymakers the confidence to remove unnecessary barriers to accessing abortion care, and to be empowered to deliver care that is based on the latest evidence rather than historic practice.

CS5.2

Medical abortion before ultrasonically visible pregnancy

Brandell K., Karolinska Institutet, Dept of Womens' and Childrens' Health, Stockholm, Sweden

Medical abortion is effective in early pregnancy, but clinical guidelines and practice differ among countries and abortion providers when the woman presents in very early gestation before an intra uterine pregnancy (IUP) can be visualized on ultrasound, referred to as "very early medical abortion" (VEMA). In addition to legislation and clinical guidelines uncertainty on efficacy and fear of an undiagnosed ectopic pregnancy can be reasons to delay the treatment.
There are few studies on VEMA and none of them randomized. Current evidence points towards high efficacy overall, but perhaps lower efficacy when ultrasound image shows an empty cavity vs when there is a probable gestational sac.
The prevalence of ectopic pregnancy is low among VEMA-patients, however when an IUP is not confirmed the patient and provider need to be aware of the risk of an undiagnosed ectopic pregnancy and follow up after abortion is needed to identify early asymptomatic ectopic pregnancies.
A multicenter RCT on VEMA vs delayed treatment are currently being conducted with the aim to evaluate efficacy, safety and acceptability.

CS5.3 (not available)

CS5.4

The 'no test' telemedicine consultation for abortion

Lohr Patricia, British Pregnancy Advisory Service, London, UK

Telemedicine, the remote diagnosis and treatment of patients by means of telecommunications technology, is increasingly used provide many aspects of abortion care. Information provision and decision-making support, pre-abortion clinical assessment, counselling for contraception and STI testing, help for self-management of medical abortion at home, and post-abortion care can all be effectively provided remotely. Providing these aspects of abortion care via phone or video call helps reduce the logistical and financial barriers imposed by requiring a visit to a clinic, and enhances privacy, convenience, and autonomy. This talk will focus on the how to facilitate an abortion consultation via telemedicine including respectful communication and developing trust, safeguarding risk assessments, estimation of gestational age and screening for ectopic pregnancy, assessing medical history and need for pre-abortion testing or other aspects of in-clinic care, and discussing contraception.

CS6.1

Testing embryos and fetuses: eugenics or healthcare?

Sandy Starr, Progress Educational Trust, London, UK

A range of methods and technologies now exists for testing embryos and fetuses. The results of such tests can inform decisions about whether and how to establish a pregnancy, or about whether to continue an already established pregnancy.
Such tests may be used in the context of approaches called 'screening' or 'diagnosis', although the terminology can be inconsistent. The scientific detail of such tests can be challenging to understand, and this scientific detail can in turn be further obscured by unclear or inconsistent terminology.
In the first half of this lecture, we shall attempt to cut through all such impediments to understanding. We shall seek to present a clear and concise picture of whether, when, why and how embryos or fetuses might be tested. (We shall also, briefly, consider the rare contexts in which an embryo or fetus can be said to be deliberately 'modified'.)
Having done this, we shall use the second half of this lecture to address the moral disagreements that surround the testing of embryos and fetuses, and that often shape relevant laws and policies.
We shall argue that such disagreements can be usefully simplified to a disagreement between two broad characterisations of testing. One characterisation seeks to delegitimise testing as 'eugenics', while the other characterisation seeks to legitimise testing as 'healthcare'.
We shall consider the historical meanings and uses of the terms 'eugenics' and 'healthcare'. We shall then proceed to consider the meanings that are conveyed by these two terms in present-day reproductive contexts.
Finally, we shall conclude with an argument that 'healthcare' is far more accurate and defensible – as a characterisation of the testing of embryos and fetuses – than 'eugenics'.

CS6.2

What can we say about "Fetal Pain"?

Derbyshire Stuart, National University of Singapore, Psychology, Singapore, Singapore

Deciding whether or when the fetus feels pain depends critically on how pain is understood and the assessment of what brain areas might support that understanding of pain. Those issues are interrelated and highly contentious. In the early 20th century, pain was understood as a unitary experience, dependent upon a neuronal relay that terminated subcortically. Evidence revealing pain to have an unreasonably variable relationship with injury, and evidence that nociceptor ("pain" fibre) activation is influenced by a network of other fibre activity and cortical activity undermined the idea of pain as a simple unitary experience and of a dedicated subcortical pain pathway. The late 20th century saw pain researchers and clinicians move towards the idea of pain as a multidimensional, subjective, experience supported by a neuromatrix of cortical regions. These ideas were supported by the 1979 IASP definition of pain as "an unpleasant sensory and emotional experience," and by the widespread use of functional imaging from the late 1980s that consistently revealed pain experience associated with activity in a wide network of cortical regions, just as the neuromatrix concept predicted. More recently the argument between pain as a unitary and simple experience supported by a relatively simple neural pathway, versus pain as a complex, multidimensional experience, dependent on complex brain activity, has returned. At least some modern neuroscientists understand pain as a relatively simple, unitary, experience - an immediate phenomenal reflection of activity in a minimal neural circuit. The minimal neural circuit is typically taken to be the midbrain subcortical structures, which develop in the first trimester and are functional by at least 18 weeks gestation. Other neuroscientists maintain that pain is a multidimensional and self-reflective experience that requires higher level brain activity (the cortex), which is not developed and functional until at least the third trimester and possibly not until several months after birth. Whether an immediate phenomenal pain experience matters morally and should influence surgical practice is also contentious. Therapeutic fetal surgery includes fetal analgesia to protect the fetus from the harmful effects of the physical reaction to the operation, which makes no sense during an abortion. Fetal analgesia has been suggested to protect the fetus from pain during an abortion, but that might not be something that can be practically achieved. The rationale of trying to protect the fetus from a raw phenomenological feel that is unknown and likely forever unknowable during an abortion is also questionable.

CS7.1

Cervical Preparation Prior to Surgical Abortion- Focus on the Second Trimester

Blumenthal Paul, Shaw Kate
Stanford University, Obstetrics and Gynecology, Palo Alto, USA

Cervical preparation prior to surgical abortion has become a global standard of care. The advantages outweigh the perceived or very uncommon risks and include: a softer, more compliant cervix yielding better instrument accommodation and removal of both fetus and placenta, expedited procedure times, decreased or eliminated need for mechanical cervical dilation, fewer uterine or cervical related related complications, lower risk of uterine perforation,and lower risk of long term damage to the cervix. This presentation will focus on options for and experience with a variety of cervical preparation approaches, with a focus on the second trimester.

CS7.2

Safety of office-based sedation for surgical abortion (1st and 2nd trimester)

Brethouwer Raina, Heemstede Nh, The Netherlands

Office based deep sedation by abortion doctor
Deep sedation, unlike general anaesthesia, is in many countries not reserved for anaesthesiologists. In the Netherlands a new guideline will be published soon, in which clear safety regulations are stated for administering sedation by other professionals than anaesthesiologists.
The data gathered from the clinics in the Netherlands show, that the structure used is more than very safe. Complications are extremely rare. Patient satisfaction is very high.
What is the structure? How is this done safely? What is the complication rate? How does this help women who need abortion?

CS7.3

Inducing fetal asystole

Reeves Matthew, DuPont Clinic, Washington, USA

The presentation will review the method of inducing fetal asystole including injection of digoxin, potassium chloride, and lidocaine and cord transection.

CS7.4

Management of difficult cases and complications in second trimester abortion

Kopp Kallner Helena, Karolinska Institutet, Dept of Clinical Sciences at Danderyd Hospital, Taby, Sweden

Whether medical or surgical abortion- abortion in the second trimester entails higher risk in uncomplicated abortions and well as in complicated abortions. These risks are due to a larger uterus and placenta but may also be due to women having intercurrent diseases, previous uterine surgery or allergies among others. Proper and evidence-based regimens for cervical ripening, uterine dilation and evacuation, and bleeding management in the second trimester will be discussed. In case evidence is lacking- expert opinion will be provided.

CS8.1 (not available)

CS8.2

Immediate post-abortion LARC

Heikinheimo Oskari, University of Helsinki and Helsinki University Hospital, Department of Obstetrics and Gynecology, Helsinki, Finland

The contraceptive efficacy of a contraceptive method in an individual woman depends on her capacity of conceive, frequency and timing of intercourse, degree of compliance and inherent contraceptive protection of the method. Women seeking induced abortion are highly fertile and likely to resume sexual activity soon after the pregnancy. In studies analyzing the need of subsequent

abortion, previous pregnancies (both deliveries and induced abortions) and young age - indicators of high fertility and sexual activity emerge as risk factors for the need of subsequent abortion. In contrast, the use of effective contraceptive methods requiring minimal daily compliance, such as contraceptive implants and/or intrauterine devices (i.e. long acting reversible contraception [LARC]) significantly reduce this risk. Therefore, safe and effective contraception, preferably with minimal daily/regular remembering is important if another pregnancy is not desired soon.
Surgical abortion continues to be the standard of care in several countries. In the absence of contraindications, all systemic hormonal methods (incl. oral contraceptive pills, and contraceptive implants, injections and patch) may be started immediately after surgical abortion. Also, insertion of IUD at the time of surgical abortion is safe, has become a standard of care and should be liberally provided.
Medical abortion is increasing used globally, and increasingly by means of telemedicine. As medications can be self-administered at home, most women undergoing first trimester medical abortion may not need to physically visit in health care at all. Similarly, as in the case of surgical abortion, all hormonal methods with systemic action can be started at the time of medical abortion. However, recognition of the high efficacy of LARC methods necessitating attendance at a health care unit, and recommendations for their liberal use in women of all ages pose a challenge to the post-medial abortion contraceptive service-delivery system.
The optimal timing on implant insertion at the time of medical abortion has been studied in randomized trials. In these studies the efficacy of medical abortion was not affected by the immediate insertion of the implant. Thus, providing contraceptive implants at the time of initiating medical abortion is a very logical and cost-effective means of providing effective long-term post-abortal contraception.
Similarly, intrauterine contraception can be initiated rapidly (either immediately or in 1-3 days) after medical abortion. Provision within one week after medical abortion is safe and no interval contraception would be needed. The challenges in early IUD provision lie in organizing the service-delivery system as well as in supporting the compliance to attend the early IUD insertion visit.
Liberal use of medical abortion minimizes the need of physical contracts with health care. This successful promotion and provision of effective LARC contraception needs similarly innovativeness and flexibility. Structure of the reproductive health care system is likely to have a major effect on how successful this is.

CS9.1

The good: positive evolutions in Europe and South-America

Martens Nausikaa, VUB Dilemma, Brussels, Belgium

Globally, it seems that only bad political decisions are made regarding abortion and evolutions in SRH-matters are only going downwards.
However, there are also many positive evolutions, there have been political decisions that can only be welcomed. I collect them for you.
Let these messages give us courage and hope that we will not give up the fight for a just regulation of abortion anywhere in the world!

CS9.2

The Bad: Europe / Asia

Bartley Julia, MVZ TFP Berlin, Reproductive Medicine, Berlin, Germany

A comparison of the abortion care in Europe and Asia, including developing nations, reveals highly differing problems and constraints. Ultimately, in both continents, individual women are still confronted with restricted or no access to abortion care.
In Europe, there has been a sustained and clear trend in recent decades toward legalizing abortion and removing political barriers. However, even in Europe abortion remains illegal in a few countries. Recent developments in Poland, where the constitutional court has issued a ban on abortion, are cause for concern in the EU. Once again, this shows that progress in the legalization of abortion is fragile. In Germany it was only this year, 2022, that a law prohibiting gynecologists from providing public information on their abortion services was banned.
Overall, the number of unwanted pregnancies in Europe has dropped by 53% and abortions by 64% since 1990, but with distinct regional differences: little change in Western Europe and most pronounced changes in Eastern Europe. In the same period of time in Asia, the decline of unintended pregnancies was only 16% while abortion increased by 12%. Abortion is restricted in most countries in Asia to safe a woman´s life through "menstrual regulation." In some, like India, abortion has been legalized many decades ago. However, recent evaluation has revealed that there is no access to comprehensive abortion care across Asia even in countries where abortion has been legalized. The percentage of illegal abortions ranges from 58% to 78% in countries where abortion is permitted under broad criteria. Furthermore, less than half of public sector facilities that are permitted to provide abortion services do so. There is still an urgent need to improve access to abortion care as well as the quality of care in most areas across Asia.

CS9.3

The Ugly: USA

Edelman Alison, Oregon Health & Science University, OB/GYN, Portland, USA

The US Supreme Court's ruling in Dobbs v Jackson on June 24, 2023 overturned the protections provided by Roe v Wade over the last 50 years. Although shocking and contemptable, the ruling is not surprising given the strategic placement of individuals with regressive beliefs and white supremacy ideology to positions of power. This decision impacts all of us; we cannot silo and ban a core aspect of reproductive health without far-reaching consequences for the US. How this will play out is sadly all too predictable. Our own nation's history with abortion shows us that when it is illegal, it does not stop and preventable morbidity and mortality rises. The US already has the highest maternal morbidity and mortality rate of any high-income country in the world.
These outcomes are not isolated to the US, copious examples exist from other countries with regressive reproductive health laws. At its core, this decision is a devastating blow for the rights and health of girls, women, and anyone capable of pregnancy as well as the health care providers who care for them. It enshrines health disparities into the fabric of US society and emboldens individuals to discriminate beyond abortion to any aspect of reproductive health or gender care. The decision will have unintended consequences beyond the health care arena including privacy rights, state commerce laws, and the economic health and stability of states and thus the US. The situation is rapidly evolving but this presentation will provide an overview of the current state of abortion care and access in a post-Roe US.

CS9.4

The European Abortion Policies Atlas - Tracking Government Policies on access to abortion in Europe

Neil Datta, EPF, Brussels, Belgium; Daidashvili Marina, EPF, Brussels, Belgium; Caroline Hickson, IPPF European Network, Brussels, Belgium; Lena Luyckfasseel, IPPF European Network, Brussels, Belgium; Irene Donadio, IPPF European Network, Brussels, Belgium

"European Abortion Policies Atlas" scores 52 European countries and territories on policies to access safe abortion, focusing on 4 criteria and 15 sub-criteria:
1 Legal Status of abortion
2 Access to abortion (time limits, unnecessary medical procedures, health system coverage)
3 Clinical care and service-delivery
4 Information and on-line information:
The criteria were established with a multi-stakeholder group of experts. Data sources: WHO Abortion Database, IPPF EN Survey and national partners survey. The Atlas does not reflect the rate of abortions in the countries.
Methodology: Analytic Hierarchy Process sets a general, overall goal and further breaks it down the headings, criteria and sub-criteria, resembling the "tree and the branches". Each final "branch", the smallest sub-criteria has its specific weight and based on the answer will receive a percentage score. Finally, the scores for each sub-criteria are added up to the total score of each country.
Results: Sweden (94%), Iceland (91%), Great Britain (89%) and Netherlands (85%) are champions on access to abortion in Europe. Poland (16%), Monaco (14%), Liechtenstein (11%), Gibraltar (8%) Andorra (0%), Malta (0%) score exceptionally poor.
Findings: 1) Archaic laws: In 14 countries/territories, abortion remains technically a crime according to the national penal codes, despite the fact that most people consider abortion to be a women's right. 2) All countries but 5 (Estonia, France, Iceland, Sweden, Switzerland) impose unnecessary mandatory medical procedures (compulsory dissuasive counselling, compulsory waiting periods or compulsory additional medical tests, additional second doctor consent etc.) to access abortion. 9 countries solely impose consent for minors
-In majority of countries (25 countries) abortion is available i.e. on request at up to 12 weeks LMP
-In 4 countries abortion is available at up to 24 weeks (Iceland, Netherlands, Sweden, UK)
-8 countries have very low gestational limits of up to 10 weeks: BiH, Croatia, Montenegro, Portugal, Serbia, Slovenia, Turkey, Northern Cyprus
-Only 19 countries allow abortion on economic or social reasons
-Only in 21 countries abortion is covered as any other medical services by national health insurance
3) Only 38 countries provide medical abortion
-34 countries provide information on contraception in the context of abortion care
-3 countries protect women from being harassed / attacked when accessing abortion (buffer zones) (Belgium, France, Isle of Man)
Only 3 countries in Europe do not allow refusal of care: Finland, Lithuania, Sweden
-26 countries allow refusal of care in abortion, which often poses a serious problem in accessing lawful abortion
4) 19 governments provide good authoritative information and 7 even combat disinformation
-7 governments actively oppose abortions by proposing anti-abortion laws
Recommendations:
Modernise abortion laws (decriminalise abortion, extend time limits)
Ensure that abortion care is covered by national health systems
Remove unnecessary obstacles in accessing abortion care (according to WHO recommendations)
Prohibit providers from legally opting out of any part of the full spectrum of reproductive health care
Provide accurate information about abortion from public authorities and counter disinformation.

Conduct additional research on key barriers – stigma, geographical discrepancies, cost, refusal of care, burden of travel
https://www.epfweb.org/sites/default/files/2021-09/ABORT%20Atlas_EN%202021-v10.pdf

CS10.1

Abortion in humanitarian settings - results from a qualitative study on health care providers' experiences of providing comprehensive abortion care in Cox's Bazar, Bangladesh

Maria Persson, Karolinska Institutet, Department of Women´s and Children´s Health, Stockholm, Sweden; *Elin C Larsson*, Karolinska Institutet, Department of Women´s and Children´s Health, Stockholm, Sweden and Uppsala University, Department of Women´s and Children´s Health, Uppsala, Sweden; *Noor Islam Pappu***,** Dalarna University School of Education, Health and Social Studies, Dhaka, Bangladesh; *Kristina Gemzell-Danielsson,* Karolinska Institutet, Department of Women´s and Children´s Health, Stockholm, Sweden and Karolinska Institutet, WHO-centre, Stockholm, Sweden; *Marie Klingberg-Allvin,* Karolinska Institutet, Department of Women´s and Children´s Health, Stockholm, Sweden and Dalarna University, Health and Social Studies, Falun, Sweden

Background: Humanitarian settings are characterised by limited access to comprehensive abortion care. At the same time, humanitarian settings can increase the vulnerability of women and girls to unintended pregnancies and unsafe abortions. Humanitarian actors and health care providers can play important roles in ensuring the availability and accessibility of abortion-related care. This study explores health care providers' perceptions and experiences of providing comprehensive abortion care in a humanitarian setting in Cox's Bazar, Bangladesh and identifies barriers and facilitators in service provision.
Method: In-depth interviews (n = 24) were conducted with health care providers (n = 19) providing comprehensive abortion care to Rohingya refugee women and with key informants (n = 5), who were employed by an organisation involved in the humanitarian response. Data were analysed using an inductive content analysis approach
Results: The national menstrual regulation policy provided a favourable legal environment and facilitated the provision of comprehensive abortion care, while the Mexico City policy created organisational barriers since it made organisations unable or unwilling to provide the full comprehensive abortion care package. Supplies were available, but a lack of space created a barrier to service provision. Although training from organisations had made the health care providers confident and competent and had facilitated the provision of services, their knowledge of the national abortion law and menstrual regulation policy was limited and created a barrier to comprehensive abortion services. Even though the health care providers were willing to provide comprehensive abortion care and had acquired skills and applied strategies to communicate with and provide care to Rohingya women, their personal
beliefs and their perceptions of Rohingya women influenced their provision of care.
Conclusion: The availability and accessibility of comprehensive abortion care was limited by unfavourable abortion policies, a lack of privacy, a lack of knowledge of abortion laws and policies, health care providers' personal beliefs and a lack of cultural safety. To ensure the accessibility and availability of quality services, a comprehensive approach to sexual and reproductive health and rights is needed. Organisations must ensure that health care providers have knowledge of abortion policies and the ability to provide quality care that is woman-centred and non-judgmental.

CS10.2

Abortion as reproductive right

Bombas Teresa, FIGO Committee for Safe Abortion, Coimbra, Portugal; *Gil Laura*, FIGO Committee for Safe Abortion, Bogotá, Colombia; *Persson Maria*, Committee on Women Facing Crises Human Rights, Refugees and Violence Against Women, Stockholm, Sweden

FIGO's vision is that women of the world achieve the highest possible standards of physical, mental, reproductive and sexual health and wellbeing throughout their lives.
Abortion is a time sensitive, essential medical service – one that should be provided in accordance with women and girls' preferences, and with safety, privacy and dignity at the forefront. It is an integral part of SRHR, gender equality, reproductive justice and universal access to healthcare.1
Global evidence demonstrates that restricting abortion with laws does not lead to fewer abortions, but to an increase in unsafe abortions and preventable maternal deaths and disability. Likewise, decriminalization does not result in an increase in the abortion rate but rather to a shift from unsafe abortion to safe abortion.2
By 2020, more than 26 million women and girls of reproductive age worldwide are in need of humanitarian aid; they are currently not only living outside their homeland, but most of them are also housed in refugee camps or urban slums. Evidence has shown that these girls and women are at increased risk of violence, including sexual violence, unintended pregnancies, higher risks during pregnancy and childbirth and high risk of unsafe abortions, with more adverse outcomes in terms of mortality and morbidity. Ensuring that communities have built-in mechanisms to guarantee girls' and women's rights, safety and basic health services during an acute crisis is crucial.3
FIGO considers reproductive autonomy, including access to safe abortion services, to be a basic and non-negotiable human right.

1 FIGO Statement, Addressing Barriers to Safe Abortion, September 2021.
2 FIGO Statement, FIGO Calls for the Total Decriminalization of Safe Abortion, February 2022
3 FIGO statement, Reaching the Unreached Women; Ensuring Health Equity for Refugee Women, August 2020.

CS10.3 (not available)

CS12.1

Abortion care as a priority in adolescent healthcare: From "shame job" to empowerment.

Moore Patricia, Royal Women's Hospital, Abortion and Contraception service, Melbourne, Australia

This presentation seeks to provide a springboard for further discussion and stimulus for research towards establishing the principles of best practice in abortion care for this population.
We will survey the global situation with regard to both unmet need and existent service models. The voices of this age cohort will be drawn on to provide illustration and insight into the challenges faced. The limits of research together with the opportunities and challenges of access to abortion and optimising service delivery will be discussed. Reference to the current global context; learnings gained and barriers presented will be acknowledged.
Finally we offer some general thoughts regarding universal principles of abortion care and adolescent health.

CS12.2

Abortion care for refugee and migrant women

Dilbaz Berna, Health Sciences University, EZH women's Health Training and Research Hospital, Reproductive Health, Ankara, Turkey

Abortion care is an important component of reproductive health. Unplanned and/or unwanted pregnancies occur as a result of consensual or non-consensual sexual activity, lack of knowledge about contraceptives, use of inefficient contraceptives such as traditional contraceptive methods, contraceptive non-use and contraceptive failure. Social, economic, cultural and religous factors besides the legal system contribute to the decision for termination of an unintended pregnancy. The laws on abortion vary from one country to another showing a wide range from legislations criminalising abortion with no or few exceptions to liberal laws that recognize the right to access safe abortion services on demand. Medical practice also has an impact on accessing abortion as in many countries abortion is not practised to the extend of the abortion laws of that country. However restrictive abortion laws do not stop abortions from happening but lead women to seek unsafe abortions. Unsafe abortion is a major health threat for women. Knowledge of laws and policies, and comprehensive abortion care services that provide confidentiaility and respect to human rights and reproductive rights are the main components requirred for accessing abortion care. Immigrants and refugees have less access to the health care facilites especially when reproductive health and abortion is considered. The barriers to accessing abortion services for the immigrants and refugees are challenging. Immigration status and thus fear of the authorities are the main barriers especially for undocumented immigrants and refugees in the detention camps. Difficulty in learning and understanding the native language and the health system of the hosting country also leads to unmet need in terms family planning and abortion services. Accompanying mental and physical health problems such as trauma, depression, also effect the immigrants' path to reaching safe abortion services besides stigma and marginilization, discrimination or percieved discrimination, lack of trust to the health care system. The right to health and reproductive health is a fundemental human right and no one should be left behind. Increasing immigrants' eligibility for public health services, development of health care resources for immigrants, mobilizing immigrant networks that provide knowledge about the laws, policies, facilities and health services are important steps that need to be taken in order to improve abortion access and abortion care among immigrants.

CS12.3

Second trimester abortion for patients with complex medical needs: don't be scared, be prepared

Henkel Andrea, Blumenthal Paul
Stanford University, Division of Family Planning Services and Research, Department of Obstetrics and Gynecology, Palo Alto, California, USA

While an overall small percentage of abortions are performed in the second trimester, many common medical conditions can make these procedures more medically and technically complex, resulting in higher rates of morbidity associated with these cases. Clinicians can mitigate – though not eliminate – much of these risks with pre-procedural planning of induction or procedure and multi-disciplinary collaborations.
Prior cesarean birth is the single greatest risk for complication during dilation and evacuation because of the increased risk of hemorrhage, abnormal placentation, and distorted anatomy. Recent data suggests that first trimester ultrasound findings may be predictive of abnormal placentation and therefore useful in pre-operative planning.
Clinicians who provide abortion care are more likely to encounter obese patients in the second

trimester because they are at higher risk for late recognition of pregnancy and delays in seeking abortion. The technical difficulty associated with positioning and visualization likely contributes to increased complications. Clinicians may consider longer instruments to account for increased distance from introitus to cervix based on increased subcutaneous tissue. If adequate exposure cannot be achieved, induction abortion may be preferable.

Many medications used for those with chronic illness interact with those commonly used in induction, cervical preparation, uterotonics, and pain management. Awareness of these contraindications allows clinicians to select appropriate pharmacologic and non-pharmacologic alternatives. Recent data suggests ulipristal may be an effective adjunct for cervical preparation, avoiding mifepristone's multiple drug-drug interactions.
Improvements in medical and surgical management in recent decades have resulted in significantly more people with congenital heart disease (CHD) surviving to adulthood. Pregnant people with CHD are particularly likely to present in the second trimester for abortion care because 1) those with CHD have an increased risk of carrying an offspring with CHD and 2) expanding plasma volume in the second trimester increases the risk for congestive heart failure, pulmonary edema, and uncontrolled arrhythmias. From the perspective of abortion care, a good preoperative assessment is essential to determine the history of repair and current physiologic status of the patient. For some with repaired or benign disease, an outpatient ambulatory setting may still be appropriate for these patients. However, many require a referral to hospital-based care where a multidisciplinary approach can optimize these patients and minimize risk.
This presentation will focus on providing participants with up-to-date evidence-based information on case management options to prevent or reduce procedural risks and complications.

CS12.4

Patterns of teenage pregnancy in Estonia over the last three decades

Haldre Kai, East Tallinn Central Hospital Women's Clinic, Centre for Infertility Treatment, Tallinn, Estonia and Sexual Health Clinic of the Estonian Sexual Health Association, Tallinn, Estonia; *Rahu M.*, National Institute for Health Development, Department of Epidemiology and Biostatistics, Tallinn, Estonia; *Allvee K.,* National Institute for Health Development, Department of Registries, Tallinn, Estonia; *Rahu K.,* National Institute for Health Development, Department of Registries, Tallinn, Estonia

Introduction: A major global overview from 2015 of trends in teenage pregnancies from mid-1990s until 2011 has shown that the steepest decline took place in Estonia. In the last three decades Estonia has undergone major socio-economic changes including profound educational and health care reforms. The study aimed to analyse trends in teenage delivery and induced abortion rates, among younger and older teens, among Estonians and non-Estonians, and to study in more detail trends in teenage repeat pregnancies.
Material and methods: The register-based study included 29 818 deliveries (1992–2019) and 25 865 (1996–2019) induced abortions among 15–19-year-old girls. Delivery and abortion rates per 1000 girls were calculated by age group, ethnicity and reproductive history. Poisson regression models were applied to estimate average annual percentage changes in delivery and abortion rates over the whole period and in two sub-periods with change-point in the trend in 2007. Trends in repeated pregnancies were investigated.
Results: During the study period delivery rate per 1000 teenagers decreased by 5.3% per year, from 49.9 in 1992 to 8.4 in 2019; abortion rate decreased by 6.0% per year, from 42.4 in 1996 to 8.6 in 2019. From 2007 onwards, decline in both trends was sharper, especially in the younger age group. Stratified analysis by ethnicity revealed faster decline in the delivery rates among Estonians than

non-Estonians, but the opposite occurred in the abortion rates with remarkable decrease among non-Estonians since 2007. The delivery rates for the first and repeat pregnancies decreased nearly at the same pace, while the abortion rates of the repeat pregnancy decreased faster than those of the first pregnancy.
Conclusions: Decreasing trend in teenage births is evident in parallel with the society becoming wealthier. The remarkable decline in teenage abortions during 24 years shows that pregnancy terminations decrease substantially when young people's rights to safe abortion, contraception, sexuality education and youth-friendly services are ensured. There remains always a small group of adolescents who become repeatedly pregnant, they need individualized approach and support, and should not be stigmatized. Differences in ethnic groups can change in the course of time.

CS13.1 (not available)

CS13.2

COVID-19: abortion and contraception - impetus or impediment?

Wellings Kaye, London School of Hygiene & Tropical Medicine, Public Health and Policy, London, UK, SACHA Consortium, LSHTM, London, UK

COVID-19 resulted in unprecedented challenges to provision of sexual and reproductive healthcare (SRH) globally. Public health measures aimed at limiting the spread of the virus served to restrict in-person health care. Global supply chain disruptions and health care staff shortages hindered provision of contraception and abortion. Behavioural and attitudinal changes impacted on need for SRH care, COVID altered possibilities for sexual contact, changed fertility intentions, increased demand for more reliable contraceptive methods and heightened the risk of intimate partner violence and attendant risk of unplanned pregnancy. The response in terms of RSH services has varied greatly by country. In some, the view was taken that 'a crisis should never be wasted' and COVID-related challenges were seen as the impetus to innovation. New abortion protocols were developed in many countries, easing access to abortion and increasing patient autonomy. Trends towards greater use of telemedicine to provide remote care and support accelerated, typically featuring ehealth consultations; contraceptive supplies and abortion medication sent direct to patient; and encouragement of home management of medical abortion without the need for prior clinical or ultrasound examination. In other countries, attitudes towards abortion hardened and a more retrograde stance was taken. In Europe, abortions were banned in six countries, including some with previously liberal policies on abortion, such as Hungary and Poland, and suspended in one. Surgical abortion was less available in many countries/regions and services were not available for women with COVID-19 symptoms. In many US states, abortion was deemed a 'non essential' procedure, and access to both medical and surgical abortion was restricted by closing clinics and introducing new laws. Irrespective of the approach taken, the changes to SRH service provision have had an effect beyond the duration of the most intense period of the pandemic. In many countries in which a more facilitative stance was taken to provision, the decision has been taken to make the COVID-related measures permanent in many settings. Conversely, some countries in which abortion was further restricted have also seen this trend intensified. The aim of this presentation is to identify service delivery models that improve availability and access to SRH services in times of public health crises; to weigh the evidence for continuity and equity of novel approaches of abortion care adopted at those times; and to describe lessons learnt for future pandemics and for SRH service provision in general.

CS13.3

Normally prescribed mifepristone, effect on abortion access, providers and safety

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6. Centre for Health Services and Policy Research, School of Population and Public Health, University of British Columbia, Vancouver, British Columbia, Canada

Background: In Canada, mifepristone became available for medical abortion in January 2017. Previously all abortions were provided by physicians, mainly as a focussed practice in urban areas, and >96% were surgical. By November 2017 restrictive regulations were removed so that mifepristone could be provided as a regular prescription by any primary care physician or nurse-practitioner (NP), dispensed by any pharmacist. We investigated trends for abortion rate, safety, method, and workforce, examining all Most Responsible Professionals (MRP) providing abortion in the province with 40% of Canada's population. We calculated MRPs per 100,000 females aged 15-49, with Risk Differences (RD) and 95% Confidence Intervals (CI).
Methods: We defined all medication and surgical abortion events from January 1, 2012 to March 10, 2020, by examining Ontario government linked health administrative data, including practitioner visits, hospital, emergency and ambulatory care admissions, and dispensed pharmaceuticals. For each abortion we identified one MRP. We examined temporal trends and rates for the rate, abortion method and safety, as well as for the number and characteristics of MRP, including age, sex, specialty, rural vs urban practice, and abortion method.
Results: Among all 315,447 abortions we identified a MRP for 311,742 (98.3%). The abortion rate remained approximately 11 per 1000 female residents aged 15-49 throughout the study period, while the proportion of all abortions provided by medication increased from 2.2% to 31.4%. The safety of abortion did not change. The rate of second trimester procedures was under 6% and suggestive of a downward trend. Compared to the expected trend, the number of MRPs increased from 11.1 to 45.3 per 100,000 reproductive-aged females (RD 34.3, CI 29.3-39.2). This increase was greatest in rural areas, rising from 1.8 to 48.7 (RD 46.9, CI 42.0-51.8). By 2019, most MRPs were GPs (66.5%) providing >80% of abortions, with 23.2% obstetrician gynecologists, and 9.1% nurse practitioners. MRPs providing fewer than 10 abortions per year rose from <120 to over 600, while the number of MRPs in all categories providing over 30 annual abortions was unchanged.
Conclusions: When mifepristone was available as a normal prescription, physicians and nurse-practitioners rapidly implemented mifepristone medical abortion in both urban and rural primary care. The abortion workforce quadrupled within two years after policy change, including more providers per reproductive-age female in rural than urban locations, while the abortion rate and safety remained stable. This policy improved access to confidential abortion care closer to home.

C13.4

Decriminalising abortion in Britain: what do patients and providers think?

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London School of Hygiene & Tropical Medicine, Department of Public Health, Environments and Society, Faculty of Public Health and Policy, London, UK

Background: The 1967 Abortion Act in Britain stipulates that two doctors must certify in good faith that an abortion is justified on the basis of at least one of five grounds which include physical or mental health. Given the fast pace of changes in the delivery of abortion services, an understanding of views towards decriminalisation amongst patients and healthcare practitioners is needed to inform any recommendations for practice and policy.
Methods: Preliminary findings from the SACHA Study will be presented drawing on data from in-depth interviews with women aged 16-43 (n=46) who had recent experience of an abortion and an ongoing national postal survey of healthcare practitioners [HCPs] (n=358) working in a range of specialities and settings.
Results: Women interviewed almost universally felt the decision to have an abortion should be completely their choice. They saw abortion as a health issue and felt it should be managed as any other medical procedure. They were often unaware that two doctor's signatures were required. Terms used to express their view of this need for authorisation included ridiculous, weird, appalling, policing and taking away control. Women considered that their reason for having an abortion did not need to be justified and that this requirement further stigmatised abortion. Some felt there was value in HCPs discussing the reason for an abortion for those who need further support and to protect people who being coerced.
Among the surveyed healthcare practitioners, those working in abortion services more commonly agreed than did those working in pharmacies or general practice that the choice to have an abortion should be completely that of the patient (98.0%, 80.4% and 77.6%, respectively). Those who reported that religion was important to them less commonly agreed. Less than half of those working in general practice (45.5%) agreed that abortion is a health rather than a legal issue and should be treated as such, compared to 70.6% of those working in pharmacies and 78.7% of those in abortion services. Nearly all those working in general practice, pharmacies and abortion services agreed that HCPs should counsel those with an unplanned pregnancy on all options available.
Conclusions: In Britain, legal requirements for two doctors' authorisation based on the reason for an abortion is outdated and removes patients' autonomy. Alongside required medical care and treatment, the role of the HCP should be to support patient decision-making and choice.

CS14.1

The abortion care education deficit in countries with restrictive legal frameworks

Mansaray Bintu, Ministry of Health and Sanitation, Dept of Pediatrics, Freetown, Sierra Leone

Sierra Leone was described in a 2016 UNICEF report as one of the most dangerous places to give birth and similarly stated in a recent article by the Washington Post as a country where pregnancy is a deadly gamble. Even though strides have been made to reduce the horrendous maternal mortality, including the 2010 introduction of the Free Health Care Initiative for pregnant women and lactating mothers, these do not cover abortion services. In 2015, the former President of Sierra Leone, Ernest Bai Koroma came close to signing a bill decriminalizing abortion but refused to do so due to push back by religious leaders even though the bill had been successfully approved by parliament. Abortion is still legally restricted in Sierra Leone, and unsafe abortion accounts for approximately

10% of maternal deaths in public hospitals. The government spends about $272 and health personnel use roughly 20.2 hours treating one severe case. Therefore, educating healthcare providers on providing appropriate, timely post-abortion care is critical.
The Making Abortion Safe Program works in collaboration with healthcare professionals in Nigeria, Rwanda, Sierra Leone, Sudan, and Zimbabwe, to improve women's and girls' access to safe abortion and/or post-abortion care. This presentation will discuss the experiences of working in Sierra Leone, a country with restrictive abortion laws, and being a champion in the Making Abortion Safe Program developing contextualized abortion care education materials, and advocacy messages, harnessing local partnerships and exploring diverse public education dissemination ideas.

CS14.2

Advocating for comprehensive undergraduate healthcare student education on abortion

Kavanagh Jayne, RCOG, Centre for Women's Global Health, London, UK

Research shows that comprehensive medical student education on abortion improves access to abortion care, decreases morbidity and mortality related to unsafe abortion and fosters conscientious commitment to abortion care. And yet abortion is often not included in healthcare student curricula, despite research showing that students globally, recognise the importance of the topic and want comprehensive teaching on it. This session will consider the importance of teaching healthcare students about abortion, outline the barriers to providing comprehensive teaching and explore ways in which these barriers might be overcome.

CS14.3

Ensuring abortion training in the United States despite restrictions

Steinauer Jody, University of California, Obstetrics, Gynecology and Reproductive Sciences, San Francisco, USA

In the United States, abortion training has been a required component of obstetrics and gynecology residency training since 1995. Despite increasing state policy abortion restrictions, integrated training has steadily increased, and this training has been shown to have many benefits. In addition, US medical students are expected to learn about abortion, and Complex Family Planning is now an accredited fellowship and certified subspecialty. In June of 2022 the US Supreme Court overturned Roe v. Wade, which means that individual states are now allowed to restrict abortion. Approximately 26 states are expected to ban abortion, and I will review the strategies we are using to ensure medical student, residency and fellowship training in those states.

CS15.1

Telemedicine for Medical abortion in France. A difficult challenge

Danielle Hassoun, Université Paris Descartes, Paris, France

The extensive reliance on telemedicine during the pandemic has accelerated changes in the use of this procedure. Regulations had to be modified to broaden its use, which before the pandemic was limited to patients pre-existing known. International experience for contraception teleconsultation demonstrates a high level of satisfaction among patients, as well as a desire among physicians to pursue this form of consultation beyond health emergencies. Regarding medical abortion, pre-

pandemic data demonstrated the feasibility, safety and acceptability of this procedure. In March 2021, High Health Authority (HAS) established recommendations extending the time frame for outpatient medical abortions up to nine weeks of pregnancy, with the possibility of offering patient's access to abortion totally or partially via video consultation. Taking the drugs in the presence of a physician is no longer mandatory, and women may have their prescriptions filled by their local pharmacy.
Conclusion The use of video consultation has proven to be an appropriate option for consultations for the practice of medical abortion, with a high degree of satisfaction among patients and health professionals as long as this remains a choice and maintains safety and confidentiality. It is considered to be a step forward towards health self-management, as recommended by the World Health Organisation, and to be progress for women, who are prepared to accept greater autonomy in managing their health. Studies outside the context of the pandemic are now needed to confirm the level of interest in this procedure and its limits.

La pandémie a été un accélérateur des évolutions en matière de télémédecine avec l'irruption extensive de ce mode d'exercice. Des modifications réglementaires ont été nécessaires pour élargir son utilisation qui était avant la pandémie limitée à des patients déjà connus.
Les expériences internationales de la téléconsultation pour la contraception rapportent un haut niveau de satisfaction des patientes et pour les praticiennes le désir de poursuivre ce mode d'exercice hors urgence sanitaire. Pour l'IVG médicamenteuse, des données antérieures à la pandémie avaient montré la faisabilité, la sécurité et l'acceptabilité de cette procédure. La Haute Autorité de Santé a établi des recommandations en mars 2021 qui vont dans ce sens jusqu'à 9SA avec la possibilité de proposer aux patientes une IVG totalement ou partiellement par téléconsultation. La prise des médicaments devant le praticien n'est plus obligatoire et les médicaments sont alors délivrés directement à la femme par les pharmacies d'officine.
Conclusion L'utilisation de la téléconsultation s'est avérée une option adaptée à la pratique des IVG médicamenteuses avec un haut niveau de satisfaction des patientes et des professionnels de santé à condition de rester un choix et de garder les mêmes exigences de sécurité et de confidentialité. Cette pratique est un pas de plus vers l'autogestion de la santé telle que préconisée par l'OMS et pour les femmes, vers plus d'autonomie dans la gestion de leur santé. Des études hors pandémie sont nécessaires pour en confirmer l'intérêt et les limites.

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CS15.2

New delay for abortion until 16 weeks of gestation: How we managed to change the French law in 2022

Faucher Philippe, APHP, Hôpital Trousseau, Paris, France

The battle to increase the legal time limit for abortion in France from 14 to 16 weeks since LMP began in September 2020 following the publication of a parliamentary report on access to abortion. In this report one could read among other things that approximately 3000 to 5000 French women were forced to go abroad to be able to obtain an interruption of their pregnancy. One of the recommendations of this report was to extend the legal deadline for abortion by two weeks. In October 2020, Albane Gaillot, a parliamentarian from the National Assembly, took advantage of the only day in the year when her small group could table a bill, to put on the agenda a modification of the law on abortion. . To everyone's surprise, the law was passed at first reading thanks to the support of parliamentarians from the presidential majority. Thereafter the bill was presented twice to the Senate, with a conservative majority, and rejected without even being discussed by the senators. It was the National Assembly that finally had the last word in March 2022 allowing the adoption of the bill and therefore the extension of the legal period for abortion. On the political level, the law was passed against the opposition of right-wing and far-right conservatives in the Assembly and the Senate, but also against the opinion of the President of the Republic Emmanuel Macron. The latter has in fact spoken out on several occasions against the extension of the legal period for abortion. However, there was a spectacular and unexplained reversal of his veto on the adoption of the bill just before the presidential elections of May 2022... Some saw it as a political calculation to recover the votes of left-wing voters. In civil society, it should be noted the constant opposition of the National College of Obstetrician Gynecologists by the prevalent voice of its president Israel Nisand but also the opposition of the National Academy of Medicine. It should be noted that the arguments put forward by these two bodies to oppose the extension of the legal period for abortion were based on wrong and false scientific basis. Fortunately, the Minister of Health had seized the National Ethics Committee in October 2020. This independent and serious body published in December 2020 an opinion in favor of the extension of the legal deadline for abortion, which was decisive in the adoption of the law. Finally, we should note the determining influence of feminist and pro-choice associations such as the French Movement for Family Planning, whose representatives have been heard on several occasions by parliamentarians and who have spoken widely in the media.

CS15.3

How to approach contraception with people with disabilities? Example of films produced by ANCIC (National Association of Abortion and Contraception Centers)

Lhomme E., ANCIC, Paris, France, APHP, Paris France

Information on sexuality and contraception is often not designed for people with disabilities. Frequently, disability is associated with a lack of knowledge about the body, prevention messages, contraception methods, etc.
Many people with disabilities need adapted and specific tools that give them access to the information they need to make independent choices about their sexuality and contraception.
ANCIC, the National Association of Abortion and Contraception Centers, developed short films and educational sheets in 2018 to help professionals address issues of sexuality and contraception during education sessions on emotional and sexual life with young audiences.
These tools were adapted for audiences with disabilities in 2021.

Three of these films will be presented here:
- "Contraception is useful"
- Contraception is freedom
- Contraception works".

These versions can be slowed down, subtitled or in French sign language.
They are available free of charge as well as the accompanying educational sheets on the ANCIC website: www.ancic.fr.

Lunch sessions

LS1.1

Pain perception and medical abortion: how can we improve our care? A single-center observational study

Andersson Karin Louise, Central Tuscan Health Care, Florence, Italy

Background: Pain perception is a complex and multifactorial concept which differs from woman to woman. To better understand the pain pattern would contribute to a better abortion care.
Objective: to improve the medical abortion care, in particular to better understand the pain pattern and how the diversity among patients results in pain perceiving differences during the procedure.
Methods: 64 women enrolled for medical abortion in an outpatient setting completed questionnaires and symptoms diaries prior to, during treatment and at follow up.
The questionnaires document demographic data such as age, education, nationality, religion, and ethnicity as well as information regarding usual menstrual pain, previous pregnancies, previous abortion history. A part was dedicated to the expected pain for the up-coming abortion and after the treatment women will be asked to fill in a questionnaire about the acceptability of the procedure. Women were also asked to rank if they perceived that they had received enough information concerning the treatment and reported at last if they have a partner/friend present during the abortion.
Results: Overall 43 % of the women perceived VAS pain 5 or more within the first 48 hours of the procedure while 14 % of the women perceived VAS pain 8-10. No differences could be seen with respect to age, socioeconomic and or religious status, previous obstetric history or circumstances in regards to the current pregnancy (partner, contraceptive use etc). What could be shown was that the expectance aspect played a determinant role as 80% declared to have been very worried previously to the procedure (compared to 39 % in the overall group).
Conclusion: this study underlines that pain perception is regardless to conventional patient characteristics. Our results stress the fact that general information and knowledge is fundamental in order to reduce concerns related to the medical abortion procedure and strategies considering this fact can contribute in reducing pain perception and be used as a tool in medical abortion management.

LS1.2

A model for telemedicine provision of medical abortion - preliminary results

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Our overall aim is to increase access to telemedicine provision of medical abortion (TEMA). Systematic research has led to a simplified, demedicalized treatment that can be self-managed through telemedicine provision of counselling and medical abortion (MA) procurement with outcomes similar to in-clinic provision. However, information is needed from well-designed trials to develop evidence based clinical guidelines. We hypothesize that efficacy of TEMA is non-inferior to standard in-clinic MA provision.
Objectives: To evaluate if efficacy, safety and acceptability of TEMA is non-inferior to in-clinic MA
Patients: Women with MA up to 10 weeks gestation fulfilling inclusion- and without exclusion criteria randomized to

Intervention: TEMA or
Control: in-clinic MA
Primary outcome: efficacy of MA defined as complete abortion without ongoing pregnancy or surgical intervention for incomplete abortion within 30 days of treatment.
Secondary outcomes. This includes evaluation of self-determination of gestational age (GA). In many settings including women seeking "home abortion" are still required a physical visit to a health care facility for GA dating the by ultrasound (US). Research shows promising results for determining GA based on women's own dating, replacing dating by US. Comparison of US and women's own dating of GA has not previously been conducted with patients randomized to receiving TM counselling or routine counselling in a setting where US examination by abortion provider is part of standard protocol. The aim of this substudy was to establish whether US is essential for determining GA in MA with TM. We compared GA based on US and based on women's own dating (last menstrual period or own estimate). Results: Mean difference between GA based on US and women's own dating was -2 days (P7 days. Conclusions: Our findings suggests that determination of GA in medical abortions with TM can be reliable without US up to GW 10.
We expect that the results of this trial will guide the implementation of TEMA with the secondary impact of earlier treatment, increased flexibility, reduced costs and increased reproductive autonomy. The need for self-care and telemedicine has become evident during the current corona pandemic and is of highest importance to ensure access to safe abortion globally.

LS1.3 (not available)

Free communications

FC.01

Self-care journeys: how digital interventions foster links between abortion seekers and providers

Pauline Diaz, safe2choose, Lyon, France; Florencia Fontana, safe2choose, Stockholm, Sweden

Background - Improved technology and deeper internet penetration have accelerated the shift toward abortion self-care demand and provision. Online abortion counselling and accompaniment services improve privacy, reduce facility-related travel costs and address other social and economic barriers for abortion seekers. This ensures stigma-free care and linkages to the broader health system.
Objective - safe2choose.org's (safe2choose) counselling and referral model aims to accommodate different types of user behavior from those favoring self-managed medical abortions to those preferring facility-based care. Through a person-centered and on-demand approach, safe2choose provides accurate guidance on different abortion methods via a secure live chat facility that is accessible online and via email. To ensure continuity of care, referrals are made to verified private sector providers as needed. Integrated feedback loops allow users to report on the quality of the referral.
Methods - Throughout 2021, using internal measurement tools, we examined total counselling and referral numbers and corresponding trends. Additionally, we also looked at the quality-of-care feedback received, and total providers registered in the database.
Results - Across 146 countries, a total of 13,000 clients were counselled; 72% were referred to local providers. A total of 1,800 providers across 85 countries were registered in the database. 94% of clients were below 13 weeks' gestation and 62% were counselled on MA; 16% had already purchased the pill. Overall user satisfaction was high, with 81% reporting being satisfied.
Conclusions - The provision of online abortion counseling and referrals can be safely and successfully implemented globally, with an overall high client satisfaction. Collaborating with formal provider networks is an opportunity to design a tracking and evaluation system that examines the viability of referral links between online and in-clinic services, and how the two can be better integrated to strengthen self-care trajectories and continuity of care.

FC.02

Results from a pilot of an enhanced contraception pathway following telemedicine abortion

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Background - Most patients receiving abortion care in Scotland undergo early medical abortion at home (up to 12 weeks' gestation). In NHS Lothian (Edinburgh and surrounding region) over 80% are provided by telemedicine. Although contraceptive counselling is part of this telemedicine model, there is less opportunity to provide some methods of contraception at the time of abortion. Bespoke pathways to improve access to post-abortion contraception are therefore needed.
Objectives - To determine whether the offer of enhanced post-abortion contraceptive support, (contraceptive counselling delivered by telephone with the offer to facilitate method provision) is utilised and results in uptake of effective contraception.
Method - We piloted the enhanced contraception pathway in NHS Lothian from February-March

2022. All patients entering the abortion service indicated whether the research team could contact them for the project. Those indicating 'yes' were contacted by text message 4-6 weeks following abortion treatment, in addition to the routine contraception counselling at the time of abortion. The text message offered a follow-up call with a nurse to discuss contraception. A decision aid was used to support selection of a method where needed. Rapid access to the chosen method was then arranged.
Results- In February and March 2022, 604 patients received abortion care in NHS Lothian. Of these, 241 (40%) agreed to further contact. 98/241 patients (41%) did not respond to the text message. 143 responded, with 103/143 (72%) declining, and 40/143 patients (28%) requesting a follow-up call. 24 of these patients (60%) changed method of contraception following the call, all selected a more effective method than they were previously using.
Conclusions - The pilot enhanced contraception pathway was taken up by a small proportion of patients, however, of those using it, more than half changed to a more effective method and the remainder accessed further supplies of their method.

FC.03

Examining impacts of approval of home use of misoprostol in England on access to medical abortion

Maria Lewandowska , London School of Hygiene and Tropical Medicine, London, United Kingdom; Daniel J. Carter, London School of Hygiene and Tropical Medicine, London, United Kingdom; Patricia A. Lohr, British Pregnancy Advisory Service, Stratford-upon-Avon, United Kingdom; Kaye Wellings, London School of Hygiene and Tropical Medicine, London, United Kingdom

Background - Home use of early medical abortion, involving the use of mifepristone and misoprostol, has been declared safe and effective by the WHO. In 2018, the Department of Health in England approved the use of misoprostol at home for abortions up to 10 weeks' gestation, following administration of mifepristone at a medical facility.
Objectives - To assess the impact of the 2018 approval of home administration of misoprostol in England on access to medical abortion.
Methods - This study uses the clinical data from the British Pregnancy Advisory Service on abortions in England in years 2018-2019. We conducted an Interrupted Time Series analysis to establish the differences between before and after the approval in access to medical abortion, based on proxy measures: the proportion of all abortions that were carried out medically, rather than surgically, and the gestational age at treatment. The analysis also tackled the question of equity of these changes, with particular focus on area-level deprivation.
Results - The analysis of the BPAS data, encompassing 145,529 abortions, suggested that there was an increase in the proportion of medical abortions and a decrease in gestational age of women experiencing abortions after the ruling. Compared to if former trends had continued, the actual proportion of EMAs was 4.2% higher in December 2019 and the mean gestational age 3.4 days lower.
Conclusions - The approval of home use of misoprostol as part of a medical abortion regimen in England was associated with material and equitable improvements in abortion access. Pre-approval trends toward greater uptake of medical abortion and declining gestational age were accelerated post-approval and were greatest in the most deprived areas of England, but not across all racial/ethnic groups, which requires further investigation. Policymakers should take the positive results of this study into consideration when reviewing rules for home management of medical abortions.

FC.04

Increasing young people's awareness and knowledge about abortion - An innovative approach

Kristina Castell, RFSU, Stockholm, Sweden

The Swedish Association for Sexual and Reproductive Rights, RFSU, has been working with abortion rights since its inception in 1933. We work with comprehensive sexuality education, advocacy and awareness raising at national and global level. In 2019 we undertook a poll among 3000 persons in Sweden regarding abortion and found out that the support for the right to abortion is high, but the knowledge about it is low in most age groups, but especially in the younger ages. In 2021 RFSU initiated an awareness project on abortion, among others by collaborating with a Swedish Cartoonist, Julia Hansen, who has created a celebrated graphic novel about abortion in 2015. Together with RFSU Ms Hansen created a shorter version of the the graphic novel which contains Julia's own story about her abortion. The story describes how an abortion is done, from Julia taking her first positive pregnancy test until she takes a new test two weeks after the abortion, which is negative. (https://www.rfsu.se/om-rfsu/om-oss/in-english/our-campaigns/two-lines-pregnant/) RFSU also developed a toolkit to be used in schools to discuss abortion in relation to the graphic novel. The graphic novel has been widely disseminated to schools, youth clinics, student health clinics etc with good results and has now been translated to English for further dissemination globally. By working with different means of IEC materials, including the graphic novel, RFSU has managed to reach a broader audience and spread awareness and knowledge about abortion.

FC.05

Trajectories and experiences of pro-choice female physicians in three Mexican states

Suzanne Veldhuis, El Colegio de la Frontera Sur (ECOSUR), San Cristóbal de Las Casas, Mexico; Georgina Sánchez Ramírez, El Colegio de la Frontera Sur (ECOSUR), San Cristóbal de Las Casas, Mexico; Blair Darney, Oregon Health & Science University, Portland, USA, Instituto Nacional de Salud Pública (INSP), Centro de Investigación en Salud Poblacional (CISP), Cuernavaca, Mexico

Background- In Mexico, access to abortion in the health sector is limited in both restrictive and legal settings. Mexican health providers lack awareness and knowledge of abortion legislation and clinical protocols. They are also known to experience stigma and violence, which further act as barriers to providing care. However, some physicians are motivated to provide abortion care. Little is known of the experiences of self-identified pro-choice physicians in Mexico, and how they came to support the right to choose in a country where abortion is highly stigmatized and restricted.
Objectives - Describe the characteristics and trajectories of pro-choice physicians in three Mexican states, and understand how their conditions allow them to form, disclose, and work as pro-choice providers or advocates in different spaces.
Method - In this qualitative study we use a feminist ethnography approach. We are currently conducting semi-structured interviews with female pro-choice physicians in three Mexican states with diverse legal, sociocultural, and political settings. We are recruiting participants within the existing Mexican Network of (female) Pro-choice Physicians. The interview guide focusses on the experiences of participants in relation to their being "pro-choice" in different spaces. We use a-priori themes (e.g. becoming, being, disclosure, and work as a pro-choice physician) and will capture additional emergent themes.
Results - Our results will provide a description of the different trajectories and experiences of participating Mexican female pro-choice physicians, as well as the conditions which influence the possibility to disclose their pro-choice stand, and work in favor of women's abortion-rights in three different Mexican states.

Conclusions - It is important to understand how best to form and support pro-choice physicians, which obstacles they encounter, and how these may be overcome. The presence of physicians who are aware and knowledgeable as well as supported and activated is essential for expanding access to safe abortion in Mexico.

FC.06

Cabergoline for lactation inhibition after second-trimester abortion or loss

Andrea Henkel, Stanford University, Palo Alto, USA; Sarah Johnson, Stanford University, Palo Alto, USA; Erica Cahil, Matthew Reeves, DuPont Clinic, Washington, USA, Paul Blumenthal, Stanford University, Palo Alto, USA; Kate Shaw, Stanford University, Palo Alto, USA

Background: Breast engorgement following second-trimester abortion is common and is both physically and emotionally painful.
Objective: To assess cabergoline's efficacy at decreasing lactation after second-trimester abortion or loss.
Study Design: This is a planned interim analysis of a double-blinded, block-randomized superiority trial (NCT04701333) comparing cabergoline 1mg once to placebo for preventing bothersome breast engorgement after second-trimester abortion. We recruited and consented pregnant people seeking abortion care between 18 and 28-weeks gestation, English- or Spanish-speaking, between April-December 2021 without contraindication to the study drug. Participants completed a validated, piloted, electronic survey to assess breast symptoms at baseline and days 2, 3, 4, 7 and 14 post-procedure.
Our primary outcome is breast symptoms on day 4, based on anticipated physiologic engorgement of stage II lactogenesis. We planned to enroll 80 patients to show a clinically meaningful 30% difference in breast symptoms (power=80%, $\alpha=0.049$).
Results: After screening 103 patients, we enrolled 40 participants. Baseline demographics were well balanced between groups: median gestational age was 21 weeks (range: 18-26), 60% nulliparous, 35% self-identified as Hispanic, 37.5% had public insurance.
At day 4, significantly fewer participants reported any symptoms in the cabergoline group compared to placebo (35% vs 100%, $p<0.0001$). This difference was significant in all four domains: engorgement (20% vs 100%, $p<0.0001$), tenderness (35% vs 100%, $p<0.00010$), milk leakage (0% vs 47%, $p=0.0006$), requiring pain relief (5% vs 65%, $p=0.0002$).
The median bother from breast symptoms on day 4 was 0 (0-4) in those receiving cabergoline and 4 (1-6) in those receiving placebo ($p<0.001$).
Reported side-effects were similar between groups: the most common were constipation (41%), headache (30%), and nausea/vomiting (13%).
Conclusion: We found cabergoline to be an effective strategy to prevent breast symptoms following second-trimester abortion or loss. Importantly, breast engorgement to be bothersome worthy of a safe, effective pharmacologic intervention.

FC.07

Service delivery trends and characteristics of women seeking early abortion care during the Covid-19 pandemic: results of an analysis of service activity data from the Irish Family Planning Association

Alison Spillane, Trinity College, Dublin, Ireland and Irish Family Planning Association, Dublin, Ireland; Caitriona Henchion, Irish Family Planning Association, Dublin, Ireland; Maeve Taylor, Irish Family Planning Association, Dublin, Ireland; Catherine Conlon, Trinity College, Dublin, Ireland

Background - National-level data collection on abortion in Ireland is extremely limited. The law requires that every abortion is directly notified to the Health Minister. The associated dataset provides information only on total abortions; abortions per month; and service-user county of residence. This study is situated in two reproductive health clinics run by the Irish Family Planning Association (IFPA). It has provided an early abortion service since legalization (January 2019). In 2020, due to the pandemic, the IFPA began providing telemedicine abortion.
Objectives - The study will (1) shed light on the characteristics of the cohort accessing abortion care through the IFPA and associated service delivery trends and (2) discuss the inadequacies of national-level data collection and its role in perpetuating abortion stigma.
Method - This is a retrospective analysis of service activity data collected by the IFPA through its abortion service during 2020-21. Demographic indicators include age, gestation, parity, contraception usage and previous abortions. It will analyse referral rates for ultrasound scanning and hospital-based abortion services. The dataset will also provide information on uptake of ancillary services (specialist pregnancy counselling, STI screening and post-abortion contraception). To build the dataset, anonymised data will be extracted from patient records held in the practice management system and transferred to an Excel file for coding. Analysis will be performed in SPSS (Version 26) to produce descriptive statistics. Currently in data collection phase. Analysis will be conducted June-July 2022.
Conclusions - Absent a comprehensive national abortion dataset, this study will provide valuable insights into the characteristics of women accessing early abortion care as well as information on service delivery trends. It will critique the data collection requirements in the 2018 abortion law, arguing for the replacement of this stigmatising provision with a section enabling the collection of detailed statistics to inform the design and delivery of abortion care.

FC.08

Ob-Gyn abortion care services and restrictions in US and Canadian Academic Teaching Hospitals

Jody Steinauer, University of California, San Francisco, USA; Kristin Simonson, University of California, San Francisco, USA; Emily Claymore, University of California, San Francisco, USA; Nafeesa Dawoodhboy, University of California, San Francisco, USA; Heather Steele, University of California, San Francisco, USA; Jema Turk, University of California, San Francisco, USA

Background - The U.S.-based Kenneth J. Ryan Residency Training Program in Abortion and Family Planning (RP) was founded to support ob-gyn residency programs to integrate abortion training. As of the end of 2021 the Ryan Program has supported 105 programs in the US and Canada, and they have varying abilities to provide abortion services due to legislative and hospital policies.
Objective - We sought to explore the current status of abortion care and restrictions in RP-supported academic programs' main teaching hospitals.
Methods - Faculty RP directors complete an annual survey, with 92 qualifying programs surveyed in 2021. We conducted bivariate analyses using STATA.
Results - Eighty-three (90%) RP directors responded in the following regions: 18 West (W), 17

Midwest (MW), 15 South (S), 31 Northeast (NE), and 2 Canada (C). Overall, 33% reported limitations in the 1st-trimester abortion care they can provide, and this varied by region (MW:71%, S:60%, W:22%, NE:6%, C:0%, $p<0.001$). Thirty-four percent reported limitations in 2nd-trimester abortion care, which also varied by region (MW:76%, S:67%, W:22%, NE:3%, C:0%, $p<0.001$.) Fifty-nine percent had mifepristone on outpatient and 77% on inpatient formularies; 78% offered manual uterine aspiration in outpatient clinics and 73% in emergency departments; 27% offered moderate sedation for in-clinic aspiration procedures; and 70% had a dedicated abortion care service. Limitations were due to institutional policies, often related to faith-based hospital directives or legal restrictions on public university hospitals and were more common in S/MW regions where legislative restrictions on abortion are more prevalent.
Conclusion - In 83 academic US and Canadian ob-gyn training programs, many reported limitations in the ability to provide abortion care. As U.S. abortion restrictions worsen and freestanding clinics close, patients who qualify for legal abortion care will depend on these academic hospitals for care. Therefore, leaders in these hospitals must expand the abortion care services they provide.

FC.09

Telemedicine for medical abortion in South Africa: a randomised controlled non-inferiority study

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Background - Telemedicine for medical abortion increases access but its use has not been described in a controlled trial.
Objectives- We aimed to determine the effectiveness, feasibility, safety, and acceptability of telemedicine abortion compared to standard care in a low-resource setting.
Methods- In this randomised controlled non-inferiority trial we recruited women seeking medical abortion ≤ nine gestational weeks at four public health clinics in South Africa. Participants were randomly allocated 1:1 by computer-generated blocks of varying sizes. The telemedicine (TM) group received asynchronous online abortion consultation and instruction, self-assessed gestational duration and had a uterine palpation as a safety measure, and took 200mg mifepristone and 800ug misoprostol at home. The standard care (SC) group received in-person consultation and instruction together with an ultrasound, and took mifepristone in clinic and misoprostol at home. Our primary outcome was complete abortion with initial treatment. Our non-inferiority margin was 4%. Group differences were assessed primarily per protocol (PP) and by modified intention to treat (mITT) analysis. The trial is registered at clinicaltrials.gov NCT04336358.
Results - Between February 28th, 2020, and October 5th, 2021, we enrolled 900 women; 153 were discontinued before the abortion. Among women using telemedicine 327/342 (95 6%), had a complete abortion compared to 367/380 (96.6%) using standard care (OR 0.77, 95% CI 0.36-1.65). The risk difference was -1.0% (95% CI -3.8%- 1.9%). Telemedicine and standard care participants had similar rates of continuing pregnancy, emergency clinical visits, adherence, and satisfaction. Both groups showed a preference for the telemedicine option. One participant (TM) had a ruptured ectopic pregnancy, another four others were hospitalized overnight (2 TM, 2 SC).
Conclusions - Asynchronous online consultation and instruction for medical abortion and home self-medication, with uterine palpation as the only in-person component, is non-inferior to standard care with respect to rate of complete abortion, and does not affect safety, adherence, or satisfaction.

FC.10

Implementing telemedical abortion service in Germany during the Covid-19 pandemic and beyond

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Background - Telemedical abortion has become established worldwide. It has been offered as an illegal option by international NGO for more than 15 years and is by far the safest method of self-organized abortion. There are several international projects that also offer this service legally. In Germany, medication abortion is used in about 35% of all abortions, which is less than in many European countries. There are clearly too few providers offering this method in some regions. During the covid-19 pandemic, the "abortion-at-home" project was developed in Berlin. The offer started in December 2020.
Objectives - The aim of the project was to establish telemedical abortion within the legal framework in Germany. This presentation provides an overview of the project, the international context and the experiences of the first two years. What is the role of offering telemedical care in Germany, where access to this method is theoretically possible through the regular health care system? Which pregnant women opt for this care and are they satisfied with it?
Methods - Mixed Methods: Analysis of standardized qualitative and quantitative questionnaires. Case reports.
Results - From December 2020 to March 2022, 100 abortions were accompanied. Monthly requests are currently 5-8. The main reasons for choosing telemedical abortion are: no clinic/practice close to home offering the method, lack of childcare during lockdown, more "convenient", more self-determined, easier to conceal. Satisfaction with the care is high.
Conclusions - Telemedical abortion is chosen in Germany within the legal framework mainly because on-site medical abortion care is not available or difficult to achieve. Occasionally, women seeking abortions consciously choose telemedicine because it allows them to decide for themselves when, where, and with whom to terminate the pregnancy. The need for telemedical abortion services exists in Germany and should be offered nationwide.

FC.11

Characteristics of women completing at-home medical abortion through online telemedicine in the Republic of Malta: 2017-2021

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Objective - To examine the characteristics of women in Malta seeking at-home medical abortion using online telemedicine. Design Population-based study. Setting: Republic of Malta. Population: Between 1 January 2017 and 31 December 2021, 1090 women requested at-home medical abortion through one online telemedicine provider (Women on Web). Mifepristone and misoprostol were shipped to 658 women (60.4% of requests).
Methods - The demographics of women and their reasons for requesting medical abortion between January 2017 and December 2021 were analysed.
Results - The number of women in Malta to whom medical abortion pills were shipped increased significantly from an average of 73 per year between 2017-19, to 178 (2020) and 261 (2021) during COVID. Women requesting medical abortion were diverse with respect to age, pregnancy circumstances and reasons for seeking it. Their mean age was 29.3; most (52.3%) were mothers with a mean number of 1.72 children. Almost a quarter (23.6%) had two or more children. 92.1%

completed their medical abortion at < 7 weeks and 98% reported they would have somebody with them during the procedure. 1.1% had an IUD and 0.6% reported they may have an STI. Among those completing a medical abortion 63% did not use contraception (n=412), and in 29.9% (n=197) the contraceptives used did not work. The most common reasons for ordering medical abortion pills online were difficulty accessing abortion because of legal restrictions (72.9%) and abortion pills not available (45.3%) in the country. Virtually all women felt confident in their decision to end their pregnancies and had no worries about their feelings regarding the medical abortion. Conclusions - Despite a complete ban on abortion, the number of women residing in Malta completing at-home medical abortions is considerable and has increased since COVID.
Keywords medical abortion, abortion policy, Malta, telemedicine, termination of pregnancy.

FC.12

The 13.5 mg, 19.5 mg, and 52 mg Levonorgestrel Intrauterine Systems and risk of ectopic pregnancy

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Objective - To assess the Pearl Index (PI) for ectopic pregnancy in women using the LNG-IUS with a hormonal reservoir of 13.5 mg, 19.5 mg, or 52 mg.
Methods - This was a retrospective cohort study. Women diagnosed with an ectopic pregnancy in Stockholm County, Sweden, between January 1st, 2014 and December 31st 2019 were identified through the electronic medical record system. The final analysis included 2252 cases of ectopic pregnancy. Information on age, reproductive and medical history, as well as current use of contraception was retrieved. Time of intrauterine device (IUD) insertion prior to ectopic pregnancy and the numbers of sold LNG-IUS during the study period were used to calculate the incidence rate for ectopic pregnancy during use per 100 women-years (Pearl Index).
Results - Among women with an ectopic pregnancy diagnosis, 105 presented with a known type of hormonal IUD in-situ of which 94 were included in the calculations of the PI. The estimated PI for ectopic pregnancy was 0.136 (95% CI 0.106-0.176) for the LNG-IUS 13.5 mg, 0.037 (95% CI 0.021-0.067) for the LNG-IUS 19.5 mg, and 0.009 (95% CI 0.006-0.014) for the LNG-IUS 52 mg. With the 52 mg LNG-IUS as referent, the relative risk for ectopic pregnancy was higher during the first year for LNG 13.5 mg (RR 20.59, 95%CI 12.04-35.21), and for both 13.5 mg (RR 14.49, 95%CI 9.01-23.3) and 19.5 mg (RR 4.44, 95%CI 1.64-12.00) during the total study period.
Conclusion - The absolute risk of ectopic pregnancy during the use of LNG-IUS at any doses was low. The results show that the lower the dose of the IUD, the higher the risk of an ectopic pregnancy. Higher dosed LNG-IUS should be considered when providing contraceptive counselling to a woman with known risk factors for ectopic pregnancy considering a hormonal IUD.

FC.13

Perspectives of pro-choice female physicians on self-managed abortion in three Mexican states

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Background - Self-managed medication abortion is a safe alternative to facility-based services in contexts where access to clinical abortion is restricted, as is often the case in Mexico due to legal restrictions or other barriers to care. It may also be a preferred option. Holistic accompaniment-models developed by feminist activists, acompañantes, are increasingly common in Mexico. Collaboration between out-of-facility abortion and the health sector can improve safety as well as expand options and facilitate incorporation of strategies that improve quality of care developed by acompañantes. However, little is known about how Mexican health care providers perceive self-managed abortion, or whether collaboration is feasible.
Objectives - This study explores experiences, perceptions, and opinions of pro-choice female physicians in Mexico about self-managed abortion and accompaniment models. We further seek to understand if and how experiences influence their perceptions and opinions.
Methods - In this qualitative research we use a feminist ethnography approach. We are currently conducting semi-structured interviews with female pro-choice physicians in three Mexican states with diverse legal, sociocultural, and political settings. We recruit participants within the existing Mexican Network of (female) Pro-choice Physicians. The interview guide focusses on participants' experiences and opinions of self-managed abortion and acompañantes. We use a-priori themes (e.g., safety and quality of care; trust) and allow for emergent themes using grounded theory.
Results - The results of this study will illustrate how pro-choice physicians in three Mexican states perceive self-managed abortion and accompaniment models, and, if and how their opinions are related to their experiences with self-management and acompañantes.
Conclusions - Understanding how abortion self-management and accompaniment models are perceived by pro-choice physicians is essential for the creation of strategies that stimulate collaborations between out-of-facility abortion models and the formal health sector in diverse Mexican states.

FC.14

Influence of the COVID-19 pandemic on abortions and births in Sweden: a mixed-methods study

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Introduction - Although considered an essential service by the WHO, there are indications that access to induced abortion care has been restricted during the COVID-19 pandemic.
Objectives - To investigate if the number of induced abortions and ongoing pregnancies changed during the first pandemic wave of COVID-19 in 2020 compared with recent years prior to the pandemic and explore possible reasons for the findings.

Design - Convergent parallel mixed-methods design. Collection of quantitative data from the Swedish National Board of Health and Welfare and the Swedish Pregnancy Register, and qualitative data from interviews.
Setting and time period
National data on abortions (January 2018–June 2020) and births (January 2018–March 2021). Interviews performed at the main abortion clinic, Gothenburg, Sweden, in June 2020.
Participants
All women aged 15–44 years living in Sweden 2018–2020, approximately 1.9 million. 15 women who sought abortion were interviewed.
Primary and secondary outcome measures
Number of abortions and births/1000 women aged 15–44 years. Themes and subthemes identified from interviews.
Results - The number of abortions and ongoing pregnancies did not change significantly during the study period compared with before the pandemic started. Interview themes identified were the following: meeting with abortion care during the COVID-19 pandemic (availability, and fear of being infected and infecting others); and the impact of the COVID-19 pandemic on the abortion decision (to catch COVID-19 during pregnancy, feelings of loneliness and isolation, and social aspects).
Conclusions - This study shows that the number of abortions and ongoing pregnancies remained unchanged during the first wave of the COVID-19 pandemic in 2020 in Sweden compared with before the start of the pandemic. Abortion-seeking women did not hesitate to proceed with the abortion. The women expressed a number of fears concerning both availability of care and their health, which could have been properly addressed by the authorities.

FC.15

Postabortion contraception use among women with and without a history of mental disorders: A Dutch prospective 5-year follow-up study

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Background - To provide optimal care, the Dutch national abortion care guidelines support immediate postabortion contraception counseling. As a consequence, uptake of contraception after abortion is supposed to be high. Surprisingly little is known about contraception continuation after abortion over time. Research has shown that women with a history of mental disorders (HMD) are at increased risk for repeat abortion, related to less (effective) contraception use.
Objectives - In the current study, we will investigate whether HMD predicts longterm contraception use after abortion and explore whether decisional autonomy may in part explain this relationship.
Method - The study is based on the first and the third (last) wave of the Dutch Abortion and Mental Health Study (DAMHS), a five-year prospective cohort study of mental health among women who terminated an unwanted pregnancy (n=325). Data were collected using structured face-to-face interviews. Hypotheses were tested using regression models adjusting for SES, age, and desire to have a family.
Preliminary results - The proportion of women using no contraception at all was strikingly similar before abortion and 5 years after. Furthermore, LARC use had increased significantly in the five years after abortion, whereas oral contraceptives and condom use had decreased. Preabortion mental disorders did not predict long-term postabortion contraception use in general (age did), but it did predict the use of highly effective contraception (LARC) 5 years postabortion ($p<.05$). Women with a history of mental disorders were less likely to use LARC postabortion. Decisional autonomy did not mediate this association.
Conclusion - Contraception nonusers may continue their contraceptive nonuse in the five years

postabortion, but other women using oral contraceptives or condoms preabortion may be more motivated to start using more effective contraception methods postabortion. Women with HMD might benefit from contraception counseling including LARC options, to ensure they make the choice that fits their needs.

FC.16

Person-centred models of abortion care: Adaptations and innovations during COVID-19

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Background - During the COVID-19 pandemic, women globally faced compounded barriers to accessing safe abortion care. The de-prioritization of abortion care, overwhelmed health systems, restrictions on movement and fear of visiting health facilities created additional challenges to safely end a pregnancy. IPPF Member Associations (MAs) developed new approaches to reach people with abortion information and care, while ensuring women's choice and quality of care.
Objective - Analyse programme data to determine effectiveness of adapted models of abortion care during COVID-19.
Method - A mixed-method qualitative and quantitative analysis was undertaken. Service statistics data from MAs in 15 countries was analysed using District Health Information Software 2 (DHIS2), and project reports and documents were reviewed to determine best practices and successes.
Results - MAs adapted models to overcome barriers to access during COVID-19, including the provision of medical abortion in clients' homes through a range of health workers (3 MAs), provision of information on abortion through a mobile app (1 MA), and providing counselling and abortion support services through teleconsultation and telemedicine (8 MAs). Pre-pandemic in 2019, 110,393 clients received abortion care. This number dropped to 104,680 (-5%) in 2020 at the beginning of the pandemic. In 2021, numbers recovered to surpass pre-pandemic levels, with 126,953 clients provided with abortion care, a 15% increase from 2019 and 21% increase from 2020. Reported abortion complication rates did not increase between 2019 to 2021.
Conclusions - Models of care that centre on the person have helped to overcome barriers to access to abortion care during the COVID-19 pandemic, and reduced barriers present pre-and post-pandemic. Recognising the value of these models of care, MAs are continuing to implement and scale-up these adaptations beyond the pandemic, as safe and effective service delivery approaches that are responsive to the needs and preferences of people seeking abortion care.

FC.17

Service user experiences of novel community medical abortion care in Ireland

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Background - Access to abortion in Ireland was extended from provision on highly restrictive grounds to provide for Medical Abortion (MA) by community and hospital providers without restriction up to 12 weeks gestation in 2019. A novel model of care was developed to 'graft on' abortion services to existing community based General Practice and Women's Health Clinics and hospital maternity care services.
Objectives - The Unplanned Pregnancy and Abortion Care (UnPAC) study captured the experiences of service users to understand their pathways to and experiences of care to inform a statutory review of the operation of the law.

Method - In-depth qualitative interviews with 46 participants recruited through GP clinics, Women's Health Clinics (WHCs), hospitals, and pregnancy counselling services were generated between December 2019 and August 2021, capturing early stages of service implementation. Interviews were transcribed, anonymised and uploaded to NVivo. A grounded theory methodology was applied to data collection and analysis.
Results - Experiences of community MA was generally positive demonstrating initiatives taken by committed providers to ensure accessible and compassionate care. Pathways to providers is facilitated by a national information helpline but uneven coverage and providers not being 'openly listed' entails stress, delays and opportunities to be obstructed. Home based MA enhances accessibility and facilitates autonomy while participants reflected on the meaning of self-managing abortion at home in contrast to having care administered in a health setting.
Conclusions - The novel Irish model of Community MA was 'grafted on' to an existing service known to be over-stretched. Tailored elements, e.g. information and nurse helpline, support access to and acceptability of the service but other features of the model do not. Self-managing MA at home prompted reflections by service users specific to terminating pregnancy that in turn prompts consideration of the evolving role of health care providers in abortion care.

FC.18

Grassroots take the lead: the creation of a European network of abortion providers

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In December of 2019, six organisations launched the Abortion Without Borders initiative, a group set up to help people living in Poland impacted by Poland's draconian abortion law. Less than three years later, this network has helped more than 40,000 residents of Poland access abortions, safely at home with pills or abroad in clinics and hospitals. Abortion Without Borders has weathered the closure of airports and borders due to Covid-19, Poland's further restriction of its abortion laws, and the criminal prosecution of one of our activists. Come here how a group of people with a single purpose have become the largest provider of abortions for people from Poland. We will overview the demographics of people who have contacted AWB for help, the percentage who choose to self-manage their own abortions (first and second trimester), the obstacles that face those who need to travel abroad, the impact of Brexit, and the importance of accessible, affordable second and third trimester abortion provision for international patients.

Presented by members from several of the groups that make up Abortion Without Borders, this session will overview a different approach to abortion provision.

Poster presentations

PP.01

Nurse practitioner prescribing of mifepristone in Canada

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Background - In January 2017 mifepristone first became available for medication abortion in Canada. In July 2017, nurse practitioners (NPs) first became abortion providers as authorized mifepristone prescribers. Already fully decriminalized in Canada, remaining barriers to abortion- such as rural and remote location, patient knowledge and stigma- could potentially be addressed through NP leadership in provision. This mixed methods study examined barriers and enablers to implementation of mifepristone in NP practice.
Objectives - To understand enablers and barriers to implementation of mifepristone prescribing in NP practice and generate recommendations to improve implementation.
Methods - Sequential exploratory mixed methods study conducted from August 2020 to May 2021 including cross-sectional survey of NPs in Canada followed by semi-structured interviews with NPs and with stakeholders in health administration, government, advocacy, regulation. We used feminist and interpretive theoretical lenses for analysis and organized data thematically. Descriptive analyses were used to interpret quantitative survey data.
Results - 181 NPs completed the survey, of whom 36% (n=65) self-identified as having provided MA and 64% (n=116) as non-providers. Mentorship was a key enabler. Barriers included limited pharmacy access, lack of surgical back-up, and employer restrictions. Twenty-two NPs and 20 stakeholders participated in interviews. Enablers included clinical leadership roles, engagement in community education and communication, and interprofessional outreach. Barriers included low priority of abortion in NP practices, lack of support from colleagues or employers, and infrastructural barriers to ultrasound and emergency services.
Conclusions - Regulatory change is insufficient to change practice. Quantitative and qualitative findings support the critical role for training and mentorship to improve uptake of NP mifepristone prescribing and address employer restrictions and resource barriers. Findings point to the need to augment abortion education to foster understanding and solidarity among colleagues. Findings can be integrated into policy, support practice changes, and direct future research efforts to advance equitable access to abortion.

PP.02

Abortion experiences during the Covid-19 pandemic in Australia: a qualitative study

Shelly Makleff, Monash University, Melbourne, Australia; Ms Sethini Wickramasinghe, Monash University, Melbourne, Australia; Professor Jane Fisher, Monash University, Melbourne, Australia; Professor Kirsten Black, University of Sydney, Sydney, Australia; Professor Angela Taft, La Trobe University, Melbourne, Australia

Background - The Covid-19 pandemic has posed challenges to the accessibility of high-quality abortion care.
Objectives -This study aimed to explore lived experiences of abortion care during the pandemic in Australia.
Method - In this phenomenological qualitative study, we conducted in-depth interviews with 15 people who obtained abortion care between April 2020 and January 2022 in Australia. Thematic analysis explored barriers and facilitators to high-quality care, drawing on concepts of equitability and person-centered care domains of quality of care.
Results - Participants sought abortions during different phases of the pandemic with a range of restrictions and mitigation strategies in place. Regardless of intensity of pandemic restrictions, participants described isolation and loneliness while seeking abortion care. They said attending appointments alone was distressing, and that friends and family often were unable to provide in-person support. Participants described being on hold for long periods when booking an appointment, having to wait weeks for an appointment, and experiencing overbooked clinics, rushed services, and cancelled appointments. Some said that masks and social distancing created barriers to empathic communication with clinic staff and providers. In some cases, the pandemic influenced choice of abortion method, with some choosing medication abortion to avoid Covid-19 infection risk and others being unable to easily access surgical abortion because of travel restrictions. In some cases, stigmatizing encounters with providers exacerbated barriers to care related to the pandemic. In terms of positive experiences, several participants said that seeking care during the pandemic allowed for privacy, time to process their emotions, and discretion when working from home.
Conclusions - Service-user perspectives can help identify barriers to abortion and shed light on enablers of access to high-quality care despite pandemic-related challenges. Lived experiences of abortion should inform strategies to facilitate access to high-quality care across diverse circumstances, with relevance beyond the pandemic.

PP.03

Becoming abortion experts: (de)medicalization of abortion in Mexico

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Abortion medication has been a revolutionary tool to advance reproductive justice and transform medicalized understandings of abortion provision and safety. The practice of non-clinical medical abortion care has a long history in Latin America but it is still a contested practice. On the one hand, most medical professionals and policymakers consider abortion a public health issue, and its non-clinical provision is seen as potentially harmful or a "last resource", despite the growing evidence of its safety and acceptability. For accompaniers abortion is political. They highlight physicians' lack of knowledge on comprehensive abortion care and position self-management as a strategy to avoid abortion stigma, criminalization and obstetric violence at healthcare centers. Given this apparent clash, in this research, I ask: how do physicians and abortion accompaniers construct knowledge and expertise surrounding medical abortion? To explore how abortion medication has been a tool to challenge traditional notions of medical expertise and how different ways to learn about abortion provision influence abortion care models. As part of an ethnographic research design, between March 2021 and March 2022, I conducted participant observation in online and in-person spaces where accompaniers and physicians discuss, learn, and share expertise about abortion care. I also conducted 18 in-depth, semi-structured interviews with abortion providers (physicians and accompaniers) in Mexico to explore how authoritative knowledge and practices translate into abortion care. From a preliminary analysis, I argue abortion provision in Mexico moves in a continuum of (de)medicalization facilitated by the organization of autonomous health movements. Self-management and accompaniment not only aim at decreasing the risks of obstetric complications and avoiding institutional stigma at healthcare centers. They are strategies to democratize the

knowledge on medical management of abortion and position it as a community-rooted self-care practice.

PP.04

Acceptability and feasibility of an outpatient 'Day Procedure' for medical induction at 13-18 weeks gestation in public sector hospitals in Nepal

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Background - In Nepal, second trimester medical inductions typically require 2-3 days of hospitalization and compete for limited Ob/Gyn beds. A one-day outpatient protocol would help high-volume facilities meet the needs of more patients while using fewer resources.
Objectives - To evaluate the feasibility, safety and acceptability of an outpatient 'Day Procedure' medical induction at 13-18 weeks' gestation.
Methods - This open-label prospective study enrolled 120 eligible abortion seekers with 13-18 week pregnancies at two government hospitals. Participants swallowed 200mg mifepristone in-clinic or at home and 24-48 hours later self-administered 400mcg misoprostol buccally within 3 hours of their outpatient clinic appointment. Repeat doses of 400mcg of misoprostol were administered every 3 hours until expulsion of both fetus and placenta. Participants who did not completely expel within the outpatient clinic's 6 operating hours were admitted as inpatients for continued misoprostol dosing. Participants were surveyed about acceptability prior to discharge and contacted two weeks later to inquire about any problems experienced since.
Results - During outpatient clinic hours, 82% had successful abortions. A median number of 2 misoprostol doses were required for complete abortion. The median time from first misoprostol dose to complete abortion was 5 hours. Eighteen participants expelled after the first misoprostol dose and prior to clinic arrival. Of the 22 participants transferred to inpatient care, 6 underwent manual vacuum aspiration to complete the process. There were no serious adverse events. Eighty-three percent reported that pain was acceptable and 98% were satisfied with the abortion process. One-fifth of participants felt the time in the clinic/hospital was too short.
Conclusions - The 'Day Procedure' model is feasible, safe and highly acceptable. Duration of outpatient clinic hours likely affects the rate of abortion completion as a 'Day Procedure'. Users should take the first misoprostol dose approximately 2 hours prior to clinic arrival.

PP.05

Not just a last resort: comparing reasons for seeking telemedicine abortion

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Background - The COVID-19 pandemic spurred new discussions about the role of online abortion services in bridging access barriers. Recently, initiatives in several countries have sought to secure permanent access to low- and no-touch telemedicine services. This presentation draws on case studies from Canada, Switzerland, Ireland, Colombia, and Thailand to understand reasons that people gave for seeking abortion via Women on Web, an international provider of asynchronous no-

touch telemedicine abortion services since 2005.
Objectives:
Understand factors underlying demand for telemedicine abortion services
Examine how preferences and constraints change following changes in legality and service availability
Methods - We analyze Women on Web's consultation data for each country from 2019-2022, focusing on the reasons that people gave for seeking online abortion services. We distinguish between factors that "push" people away from in person services due to it being difficult, uncomfortable, or unsafe to access said services, and factors that "pull" people towards online services due to preferences for how they would like to receive care. The legal and service organization context underlying each case study are discussed with corresponding features of the reasons analysis, as well as longitudinal patterns in the data when feasible.
Results - Across contexts, people identified a mix of barrier and preference-based reasons for seeking online abortion services. Needing to keep one's abortion a secret from partners or family was a widespread concern between countries. In legally restrictive contexts, reason profiles were more heavily weighted towards access barriers, with a transition towards more preference-based reasons following legalization.
Conclusions - Demand for telemedicine abortion persists even where in-person services are available. This is partially attributable to persistent access barriers, however, in many cases demand is driven by a preference for online no-touch services and/or self-management of abortion.

PP.06

Evaluation of a telemedicine medical abortion service using the "no-test" protocol in Ukraine and Uzbekistan

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Background - The COVID-19 pandemic restrictions threatened access to health services, including abortion services. Telemedicine emerged as an unseen benefit of pandemic and fostered to improve access to medical abortion services.
Objective - To pilot and evaluate the safety, feasibility, and acceptability of a telemedicine medical abortion (TMA) service model using the "no-test" protocol in Ukraine and Uzbekistan.
Method - Between October 2021 and February 2022, women who contacted two study sites in Kyiv and Tashkent seeking first trimester abortion, who met eligibility criteria, and who were interested in TMA service without pre-treatment in-person tests, scheduled a time for telemedicine consultation with study provider. Study investigators provided counseling by phone or video. Participants received medications by mail or courier service or picked them up at the study clinics as determined during the consultation. Study provider contacted participants at a scheduled time to assess abortion outcomes based on symptoms and urine pregnancy test result.
Results - Eighty-nine women participated in the study. All participants received MA medications the same day as their first contact to the study clinic for counselling, and none of them experienced any problems receiving the medications. All except two women (97.7%, n=87) followed provider instructions on timing of drug ingestion. The vast majority of participants were very satisfied or satisfied with the TMA service (95.5%, n=85) as well as with speaking to the provider remotely (98.9%, n=88). Eighty-five (95.5%) women had a complete abortion without a procedure. Seventy-two (81%) women avoided medically unnecessary in-person visits to the clinic. No serious adverse events occurred.
Conclusion - Telemedicine medical abortion using the no-test protocol is safe, effective and is feasible and acceptable for women in Ukraine and Uzbekistan. Provision of abortion services through

telemedicine has a crucial potential to improve access to abortion services as well as protect women's safety during a crisis.

PP.07

Self-managed medical abortion in the UK: what makes for a 'good' experience

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Background - During covid, telemedicine self-managed medical abortion (SMA) became a reality in the UK. A number of quantitative studies found safety and efficacy with telemedicine to be as good as with in-person care (Aitken et al 2021; Porter et al 2021; Meurice et al 2020; Reynolds-Wright et al 2021). The studies also found high levels of acceptability: for example, Porter et al found that 66% would choose SMA again and Reynolds-Wright et al found that 78% rated their care as very acceptable and 17% as somewhat.
Objectives - To examine, in depth:
What makes for a 'good' SMA experience
What might improve the experience for the minority of clients who reported 'somewhat acceptable' or 'not acceptable' experiences
Why some people may not want to repeat the experience were they to need another abortion
Methodology- This was a qualitative research study based on a story-telling interview with 20 participants.
Results: Support existing quantitative research findings that self-managed medical abortion was welcomed
Bodily experiences and emotional responses are connected
Positive experiences are associated with:
a strong positive connection with the abortion provider established in telephone consultation
emotional support, as well as informational support, from abortion providers and others
feeling safe and comfortable at home
less intense unpleasant bodily experiences
Negative experiences are associated with:
Unpleasant bodily experiences, especially severe pain
Uncertainty and fear about what to expect
Isolation due to covid lockdowns
Conclusions - This research shows the value of qualitative research in understanding minority, as well as majority, experiences. The results reinforce the importance of supported self-managed medical abortion. Support can come from a variety of sources and should include emotional support as well the provision of accurate and understandable information. With appropriate and constant support people can take abortion control into their own hand.

PP.08

Attitudes towards abortion among German medical students and gynaecologists – a qualitative study

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Background - While abortion is a common medical procedure in Germany, the number of facilities that perform abortions has declined by 45% between 2003 and 2020. As existing data do not paint a

complete picture of the factors that influence this decline, an understanding into the perspectives of health care professionals is necessary.Objective - We set out to examine medical students' and gynaecologists' personal attitutes on abortion to identify barriers that might prevent them from providing abortions.
Method - We used a qualitative research design consisting of in-depth semi-structured one-on-one interviews with 14 medical students and four gynaecologists. Interviews were audio recorded and transcribed verbatim. Data analysis was based on qualitative content analysis guidelines.
Results - Many interviewees perceived abortion as a tabooed and legally intimidating issue. Respondents obtained their knowledge about abortion from media, religious education at school or their own experiences with abortion. While the influence of Christian beliefs in the personal environment of interviewees was widespread, abortion was largely not discussed in their medical education or residency. Most students wanted abortion providers to work professionally but considered it a fundamental right to object abortion provision on personal grounds. Fear of professional or private stigmatization and lack of education were cited as barriers by medical students to professionally engage with the issue and subsequently provide abortions.
Conclusions - Universities and teaching hospitals should systematically teach abortions to counteract the spread of prejudices and help develop a professional attitude towards this common medical intervention. The spread of abortion stigma should be politically countered and doctors should be better protected against anti-abortion activities; the planned abolition of the criminal law section 219a, which prohibits doctors from providing information on abortion, is a first step towards more legal certainty for physicians. Decriminalization of abortion should be adopted in line with international public health recommendations.

PP.09

“I know what it’s like to have a baby”. Abortion decision making among Dutch mothers.

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Background - More than half of Dutch abortions are among women who are mothers. Being a mother prior to having an abortion may complicate the decision-making process, because mothers may have stronger maternal feelings, yet they may also find the decision easier, because they know the impact it has on their life to have a child.
Objectives - The aim of this study was to investigate whether motherhood affects the decision-making process among women who had an abortion. First, we compared mothers to nulliparous women on experienced decisional difficulty, decisional certainty, emotional tax of the unwanted pregnancy and abortion, and positive and negative emotions post-abortion. Second, we investigated the number and type of reasons for the abortion among these groups.
Method - The study is based on the first wave of the Dutch Abortion and Mental Health Study (DAMHS), a five-year prospective cohort study among women who terminated an unwanted pregnancy (n=325). Data were collected using structured face-to-face interviews. We used regression models to test our hypotheses and controlled for age, level of education, having a partner and living situation.
Preliminary results - No significant differences were found between mothers and nulliparous women for any of the outcomes, apart from reasons for abortion. Compared to nulliparous women, mothers less often mentioned age, financial situation, or unstable partner relationship as reasons for the abortion, and more often mentioned that they do not want (more) children. Nulliparous women also mention significantly more reasons than mothers.
Conclusion - Even though motherhood affects the reasons they have for terminating the unwanted

pregnancy, it does not seem to affect the intensity or emotional tax of the decision process. The results do not indicate that mothers need specific support in the decision-making process.

PP.10

An eight-step plan to advocate for comprehensive medical student teaching on abortion

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Background - Exposing medical students to comprehensive abortion teaching:
Increases access to safe abortion and decreases abortion-related morbidity/mortality
Prepares students to provide competent abortion-related care when they qualify
Fosters conscientious commitment to abortion care and sustain the workforce.[i]
Medical students view abortion care as essential healthcare and want comprehensive teaching. Yet, abortion is often not included in curricula and when it is, focusses on ethico-legal aspects with minimal clinical training. Furthermore, educators face numerous barriers, including lack of curriculum time, minimal clinical opportunities and the perception of abortion as a sensitive topic.[ii]
Objective -To design and pilot a toolkit for improving medical school teaching on abortion care. Method - Doctors for Choice UK (DfCUK) have developed an eight-step plan on advocating for comprehensive medical student abortion education:
Identify curriculum champions
Find out what is currently taught
Find out what students think about teaching
Identify curriculum time for teaching
Present evidence to curriculum leads/negotiate adequate teaching time
Design/adapt learning materials/source clinical placements
Provide teaching
Evaluate teaching
In January 2022 DfCUK recruited 40 volunteer healthcare providers and medical students to its Curriculum Champions project. They will be supported through the eight-step plan to introduce comprehensive abortion teaching in the 2022/23 academic year.
Results - The initial evaluation of this project, including quantitative and qualitative data, will be presented a FIAPAC.
Conclusions - DfCUK's Curriculum champions project aims to ensure the provision of comprehensive abortion teaching to all UK medical students. If the pilot is successful, the project will be rolled out to nursing and midwifery schools.

[i] Steinauer J, DePiñeres T. The importance of including abortion in undergraduate medical education. In: Landy U, Darney PD, Steinauer J (Eds). Advancing women's health through medical education. CUP; 2021. pp.143–50. [ii]Ibid

PP.11

Who is responsible for postpartum contraception advice and provision? The perspective of hospital-based maternity clinicians in NSW, Australia

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Background - Many pregnancies in the first year after a birth are not intended. Access to postpartum contraception is critical for the health of the mother and subsequent pregnancies. In many maternity settings in Australia, the roles and responsibilities of maternity care providers (including midwives, obstetricians and general practitioners) in providing postpartum contraception information and services is not always clear, and there is no consistent system or process to ensure timely access.
Objective - We undertook an analysis of interview data conducted with hospital-based maternity clinicians as part of a larger study on midwifery provision of contraceptive implants in New South Wales, Australia, to document their views regarding access to postpartum contraception and clinician responsibilities.
Methods - Interviews were conducted with maternity hospital clinicians (midwives, doctors, midwifery managers and clinical midwifery specialists) in two hospitals. Reflexive thematic analysis was used for the analysis of interview data. Themes relating to postpartum contraception access, timing of contraceptive discussions and the role of clinicians were identified.
Results - Interviews were conducted with 21 hospital-based maternity clinicians. Participants suggested contraception discussions and provision are a shared responsibility by maternity care providers but identified inconsistencies and issues with current approaches. Ensuring postpartum contraception was accessible in hospital, primary care and community settings was raised.
Conclusion - Postpartum contraception discussions and provision are regarded as a shared responsibility by maternity care providers. This would ideally be led by the primary provider. These services are not routinely available or always easily accessible in Australian maternity care settings, however, and there is a lack of consistency in how postpartum contraception is managed. Access to postpartum contraception could be improved through routine inclusion of contraception discussions during antenatal and postpartum care, and greater collaboration between maternity care providers in hospital, community and primary care settings to support continuity of care through the postpartum period.

PP.12

Understanding site users to design an improved Medical Abortion Commodities Database (www.MedAb.org)

Catherine Kilfedder, International Planned Parenthood Federation, London, United Kingdom

Background - In 2018, IPPF launched the Medical Abortion Commodities Database (www.MedAb.org) to house information on availability of quality misoprostol, mifepristone and combipacks at country level. The primary target audience included people seeking information to inform policy and programmes. In 2021, site use grew significantly, with 30,827 active users compared to 773 in 2020. Most of these were new users to the site.

Objectives - To understand MedAb.org users and rebuild a site that meets their needs and is easy to use.
Methods - We used a mix of quantitative and qualitative methods, including a desk review of site use analytics from 2021, a pop-up questionnaire to users on the site for seven weeks in early 2022, and virtual interviews with seven site users or potential site users. The data was analysed to identify key user characteristics and user needs.
Results - Most site users in 2021 were in low- and middle-income countries in Africa, Latin America and Asia. The predominant language of users was Spanish, followed by English and French. In the second half of 2021, the country with the most users was Mexico. The pop-up survey question had 2,609 respondents; 55% were individuals seeking abortion care information or services. The second largest group was researchers (30%), followed by academics (13%). Procurement and programme managers comprised only 1.5% of all respondents. The interviews indicated the site remains useful and relevant. Users preferred to search for commodities by country and wanted clarification on how we defined quality and availability.
Conclusions - MedAb.org fills an important knowledge gap. We are reaching different groups than our original intentions, such as researchers and academics; therefore, the site needs to meet a broader range of user needs. With such a large group of individuals seeking abortion care accessing the site, we need to signpost more clearly to trusted partners.

PP.13

Expanding access to abortion care through medical abortion: findings from the Global Comprehensive Abortion Care Initiative

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Background - The Global Comprehensive Abortion Care Initiative (GCACI) was implemented by the International Planned Parenthood Federation (IPPF) between 2007 to 2021. The programme expanded access to abortion care, including medical abortion, through IPPF Member Associations (MAs). The programme supported MAs in 23 countries in Africa, the Middle East, Europe, and Asia.
Objective - Analyse programme data to determine significance of medical abortion in expanding access to comprehensive abortion care in 14 countries.
Method - A mixed-method qualitative and quantitative analysis was undertaken. Service statistics data from MAs in 14 countries was analysed using District Health Information Software 2 (DHIS2). Findings from key informant interviews with staff from nine MAs using a semi-structured interview guide were analysed.
Results - Between 2008 and 2021, MAs in 14 countries provided 313,159 clients with a medical method of abortion (either combined regimen of mifepristone and misoprostol or misoprostol-only). In 2008, 9,043 clients were provided with an abortion, with 8% receiving a medical abortion. In 2021, 72,699 clients were provided with an abortion, with 56% receiving a medical abortion. Medical abortion accounted for 58% of total growth in abortion clients from 2008 – 2021. By 2016, medical abortion had overtaken surgical abortion as the most common method of abortion provided. In 2021, in 8 out of 10 MAs providing both medical and surgical methods of abortion, the majority of clients were provided with medical abortion. Staff from five of nine MAs interviewed, mentioned medical abortion as key to improving access to abortion.
Conclusions - Medical abortion is transformative in improving access to abortion care. While individuals' choice between abortion methods is an important value for person-centred care, medical abortion has proven particularly effective at expanding access to abortion care in a wide range of countries and settings, leading to rapid scale-up in the provision of abortion care.

PP.14

Long-acting reversible contraception and satisfaction with structured contraceptive counselling among non-migrant, foreign-born migrant and second-generation migrant women: evidence from a cluster randomised controlled trial (the LOWE trial) in Sweden

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Background - Lower contraceptive use and higher abortion rates among migrants compared to non-migrants have been reported in European studies. Results from the Swedish LOWE trial showed that structured contraceptive counselling led to higher uptake of long-acting reversible contraception (LARC) compared to routine counselling.
Objectives - We aimed to evaluate secondary outcomes from the LOWE trial among non-migrants, foreign-born migrants and second-generation migrants. We analysed the effects of structured counselling on LARC choice, initiation and use, and satisfaction with the counselling material among the three participant groups.
Method - Between 2017 and 2019 a cluster randomised controlled trial (the LOWE trial) was performed at abortion, youth, and maternal health clinics in Stockholm, Sweden. The structured counselling material consisted of an educational video, four key questions, an effectiveness chart and a box with contraceptive models.
Results - We analysed data from 1295 participants. When controlled for non-migrants, foreign-born migrants and second-generation migrants we found that participants who had received the structured counselling chose LARC to a higher extent (adjusted odds ratio [aOR] 2.85, 95% confidence interval [CI] 2.04-3.99), had higher LARC initiation rates (aOR 2.90, 95% CI 1.97-4.27), and higher LARC use within the 12 months follow-up period (aOR 2.09, 95% CI 1.47-2.96) compared with those who had received routine counselling. The majority of the non-migrants, foreign-born migrants and second-generation migrants found all parts in the structured counselling material satisfactorily. However, a higher proportion of foreign-born migrants (58/84, 69.0%) and second-generation migrants (40/54, 74.1%) found the effectiveness chart to be supportive in contraceptive choice compared with non-migrants (259/434, 59.7%) ($p = 0.048$).
Conclusions - Structured counselling increases LARC choice, initiation and use when controlled for migration background. Also, a high satisfaction with the intervention material was seen. Our findings are important to improve an equal access and quality in contraceptive counselling and progress towards Agenda 2030.

PP.15

Pre-abortion contraceptive planning predicts the rate and type of post-abortion hormonal contraception use – a registry-based study from Finland

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Background - Women undergoing an induced abortion are at higher risk for a subsequent induced abortion. The incidence of unintended pregnancies and subsequent abortion can be affected with effective contraceptive methods. Little is known concerning hormonal contraceptive (HC) choices and its compliance after an induced abortion.
Study design - We identified 8428 women undergoing abortion between July 2017 and December 2018, and their planned post-abortion contraception using the Finnish national Register of Induced Abortions. The redeemed prescriptions of HC were identified from the Prescription Centre served by Kanta Services. We examined the types and prevalence of HC methods chosen at the time of the abortion, and how they corresponded to actual post-abortion HC use during a one-year follow-up. Additionally, we assessed factors affecting post-abortion contraceptive choices by using Poisson regression models.
Results - At the time of the abortion 83% (n=7023) of the women were planning to start using HC. The most often planned method was the levonorgestrel-releasing intrauterine device (n=2844). Planning any HC pre-abortion was associated with higher probability to purchase HC after the abortion (incidence rate ratio IRR 2.30, 95% CI 2.07-2.55), especially in case of vaginal ring (IRR 42.66, 95% CI 33.89-53.71) and patch (IRR 156.33, 95% CI 111.31-219.55). The following variables were associated with lower IRR for starting HC after the abortion: highest education level bachelor or missing information on education, civil status married or divorced and history of delivery or induced abortion.
Conclusions - Majority of women undergoing abortion plan to use HC for post-abortion contraception. Planning any HC method at the time of an induced abortion is the most important predictor of starting the method in the year after the abortion. Furthermore, several background factors affect the HC choices and its post-abortion use.
Keywords: abortion, hormonal contraception, contraceptive choice

PP.16

Aya Contigo: integrating emotional support into a self-managed abortion and contraception mobile application for Venezuelan women and girls living amidst a humanitarian setting.

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Background - In humanitarian/fragile settings that face restrictive abortion laws, digital health interventions can be valuable in providing evidence-based information and emotional support for individuals seeking abortion care. Feminist accompaniment has been shown to improve the quality of a person's abortion experience, however since the Covid pandemic, the need for virtual tools has become more apparent to compliment these efforts. Aya Contigo is an evidence-based mobile application, which was co-created with Venezuelan women and girls to provide accompaniment and emotional support as they self-manage their medical abortions. Evidence on how this emotional accompaniment supports the quality of an individuals' experience, particularly through a digital platform is needed and this implementation study aims to do this.

Objective(s) - The objective of this evaluation is to demonstrate how virtual accompanier can positively impact the emotional well-being of individuals self-managing their medical abortions in a humanitarian context, ultimately providing insights on what entails a quality abortion experience.
Methods - Using a mixed-methods design, individuals who engage with the virtual chat will be invited to complete a 1 week follow-up survey. Eligibile participants will be invited to participate in a 20 - 30 minute interview over WhatsApp to understand if/how Aya Contigo met their emotional needs and navigate their abortion experience. Backend analytics will be used to analyze user flow and their interaction with the self-care sections of Aya Contigo.
Results - Evaluation is ongoing. Preliminary results highlight that Aya Contigo has been an important space for Venezuelans to feel respected, reassured and empowered. Moreover, it is being seen as complimentary to in-person accompaniment that they may receive from feminist collectives.
Conclusions - Digital health interventions for self-managed abortion and contraception care in humanitarian/fragile settings has the potential to support the emotional well-being of abortion seekers, ultimately improving the quality of their experience.

PP.17

Long-term maternal psychosocial stress after unintended pregnancy: findings from the Dutch prospective birth-cohort ABCD study

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Background - Unintended pregnancies (UP) have been associated with poorer mental health outcomes for women, yet evidence is mixed. Different results have been found for different pregnancy outcomes, but also for unplanned and unwanted pregnancies. Research into associations between UP and psychosocial stress (PS) postpartum is scarce, especially when the UP is carried to term. It is investigated whether carrying an UP to term is associated with short- and long term maternal PS.
Methods - This study is part of the ongoing population-based birth cohort study in Amsterdam, the Netherlands (ABCD-study) (n = 4962). UP was measured as a multidimensional construct, consisting of a total score based on self-reported data on pregnancy planning, desire and happiness around 16 weeks' gestation. Three months postpartum, anxiety and depressive symptoms were assessed, using self-reports on the STAI and CES-D respectively. Five and 11 years postpartum, PS was assessed using subscales of the DASS-21. Multivariable linear regression analyses were performed, with a total UP score predicting depression and anxiety separately at different time-points.
Results - Bivariate analyses showed that women who were younger, single, unemployed, had a migrant background, lower level of education and experiences with abuse reported higher UP scores ($p < .001$) and more symptoms of anxiety and depression ($p < .001$). While controlling for these confounders, women reporting higher UP scores reported significantly more symptoms of depression and anxiety over time, both 3 months and 5 years postpartum. However, 11 years postpartum, having carried an UP to term was no longer predictive of maternal PS.
Conclusion - Having carried a (strongly) UP is associated with increased maternal PS on the short to medium term, but this impact seems to diminish on the longer term (>11 years). Results provide opportunities for the development of interventions to support women having carried an UP to term.

PP.18

16 years and 22.000 emergency contraception pills provided to teenagers and youth in a Barcelona Youth Sexual Health Center. What have we learnt?

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The emergency contraception pill (EC) was approved in 2005 in Catalonia (Spain) and has been offered free of charge to public health centers since then in Catalonia region. At Barcelona's Youth Sexual Health Center we started the distribution (2005) and since then we have offered more than 22,000 pills free of charge to teenagers and young people up to 30 years old. The demand of EC in our center has increased enormously during these 17 years and in 2021 we offered 2.041 pills. This communiction aims to show the evolution of users' profile in relation to age, origins, contraceptive methods used, previous pregnancies or the repetition of intakes, amongst others. All data is extracted from the center medical records. All users sign an informed consent in their first visit. 54% of all women taken EC were under 18 years all. This percentage has changed considerably since 2005 when only one of out three women were under 18. The user's average age has been 18.66 years. 72% of all users had taken just once the EC. And amongst those who repeated the intake in the same years only 3% had taken 3 or more pills a year. The average age at their first vaginal coitus is 16.3 years and 56.8% have had such relationships before the age of 17. As per the contraceptive method, 87% stated that they regularly use condoms. EC demand has increased over the years and the user's profile has evolved. The population asking for EC is currently much younger than in the past. We believe that the existence of youth-friendly centers with easy access is key to the provision of EC, especially for adolescents.

PP.19

Method of anesthesia impact on total operating room time for second trimester surgical abortion

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Despite the multiple options available for intraoperative anesthesia for second-trimester abortion, few studies have directly compared the outcomes of these various modalities. Recent data suggest that monitored anesthesia care (MAC) without insertion of advanced airway devices has a low incidence of anesthesia-related complications. The objective of this study is to quantify select clinical outcomes in second-trimester surgical abortion patients who receive MAC versus general anesthesia (GA). This retrospective study evaluated clinical outcomes among surgical second-trimester abortion patients receiving GA versus MAC at Stanford Hospital from 2019-2021. We collected baseline demographics, total operating room (OR) time, surgical time, anesthetic time, post-anesthesia care unit (PACU), blood loss, complications, and OR-PACU medications. 192 patients contributed study data: 125 GA and 67 MAC (as-treated cohort). We propensity-matched 57 MAC patients to 57 similar GA patients (as-matched cohort) by estimating the exposure propensity score for receiving GA compared to MAC anesthesia, then applying one-to-one nearest-neighbor matching with replacement and a fixed caliper range of 0.01.
The as-matched analysis found significant differences in mean+SD total OR time (60.1+15.9 min vs 49.2+11.5 min, p <0.0001), non-surgical anesthesia time (33.5+14.3 min vs 26.1+6.9 min, p=0.0007), and estimated blood loss (162.8+391.5 mL vs 87.3+45.8 mL, p<00001) between those receiving GA and MAC, respectively. The as-treated analysis found the adjusted odds of total OR time >60 minutes (aOR 3.2 95% CI 1.5, 6.6) and estimated blood loss >100 mL (aOR 3.3 95% CI 1.4, 7.5) to be significantly higher in those receiving GA compared to MAC. In linear regression, GA (p=0.004), surgical time (p=0.001), and ASA3+ status (p=0.01) were significantly associated with longer total OR

time. Patients receiving MAC had significantly shorter total OR time, shorter non-operative anesthesia time, and less estimated blood loss than those receiving GA. Providers should consider these benefits when choosing an anesthetic method.

Other posters

After an abortion

P.01

An increase in the use of misoprostol in the treatment of incomplete abortions after a training intervention: A quasi-experimental study in Malawi

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Background - Unsafe abortion is a major cause of maternal mortality, especially in low and middle-income countries with restrictive abortion laws, such as Malawi. Incomplete abortion is a common complication that can lead to bleeding, infections, and potentially death if left untreated. Misoprostol is a safe and efficient way to treat incomplete abortions. Still, many countries, such as Malawi, use old-fashioned curettage as the primary treatment, which has a higher risk of complications and is more expensive.
Objectives - This study aimed to see if a training intervention could increase the use of misoprostol in the management of first trimester incomplete abortions in Malawi.
Methods - We used a quasi-experimental study design with a training intervention on the use of misoprostol in the treatment of incomplete abortions. A three-hour theoretical training was conducted at three public hospitals in July 2020. Two hospitals where no intervention was done were added as controls. Clinical data were collected from records of women treated for incomplete abortion in June-July 2020 (baseline) and July 2021 (endline).
Results - In total, data were collected from 865 women before and after the intervention. A significant increase in the use of misoprostol from 22.7% (17.9-28.0) to 35.9% (30.5-41.6) was seen at the intervention hospitals. At the same time, there was a decrease in the use of curettage from 48.1% (41.9-54.3) to 39.4% (35.3-42.6). A similar trend was not seen in control hospitals.
Conclusion - A training intervention is an efficient way of increasing the use of misoprostol in the treatment of incomplete abortions in Malawi. Increasing the use of medical management will make treatment of incomplete abortions cheaper, easier and more accessible. Increasing access to high-quality post-abortion care for women in Malawi could help reduce maternal mortality and morbidity, hence further training interventions are recommended.

P.02

Women's perceptions and experiences of misoprostol in the treatment of incomplete abortions: a mixed-methods study in Malawi

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Background - Unsafe abortion is among the leading causes of maternal mortality in countries with restrictive abortion laws such as Malawi. Incomplete abortion is a common complication that often needs to be treated with uterine evacuation to avoid further complications. Even though medical management with misoprostol is the recommended method it is rarely used in Malawi, and more expensive and invasive methods such as curettage are still being used. To improve post-abortion care in Malawi more knowledge is needed on women´s experiences and preferences of post-abortion care.
Objectives - This study aimed to explore women´s perceptions and experiences with misoprostol in the management of incomplete abortions in Malawi.
Method - A descriptive cross-sectional study that used mixed methods was conducted in three hospitals in central Malawi. A total of 400 women treated with misoprostol for incomplete abortions filled in a questionnaire, and in addition 24 in-depth interviews were conducted. The quantitative data were analysed using STATA 16.0 and the in-depth interviews were transcribed, coded, and analysed using thematic analysis.
Results - Most participants, 374 (94.0%), were satisfied with misoprostol as a treatment for incomplete abortions. Moreover, 361 (90.3%) preferred misoprostol and regarded it as a more reliable and beneficial treatment. Few women, 46 (11.5%), reported undesirable side effects, and the majority, 364 (91.0%), would recommend misoprostol to friends. Three themes emerged from the in-depth interviews: experienced effects of misoprostol, support offered to women by health care workers, and perceptions of women after taking misoprostol.
Conclusion - The use of misoprostol in the treatment of first trimester incomplete abortions is accepted and regarded as beneficial by women receiving post-abortion care in Malawi. Further implementation of misoprostol in the treatment of incomplete abortions in Malawi is recommended.

Conscientious Objection

P.03
HOW MUCH DOES CONSCIENTIOUS OBJECTION LIMIT ACCES TO ABORTION IN ITALY?

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Conscientious objection in Italy is considered the bottleneck of the service, considering that abortion can only be practiced in public hospitals, with few exceptions, and only by public gynecologists. According to the latest national data available in 2019, the gynecologists available to perform abortions are 1,488 (33%) out of 4,510 (67%). Over the decades, the number of non-objective gynecologists has remained constant even though the number of abortions has decreased by 70%. Since the peak year of 1982, abortions have dropped from 234,000 to 67,000 in 2021, while non-objective gynecologists were 1,607 in 1982 and 1,488 in 2019. Overall, 72% of women abort within

14 days of request. There are regional differences, but a significant picture comes from the data of the two minor regions Valle d'Aosta and Molise. In Molise there are 2 (7.7%) out of 26 (92.3%) non-objectors, they do 260 IVGs per year (5 per week) and have the shortest waiting times in Italy. In Valle d'Aosta, on the other hand, there are 10 non-objectors (76.9%) out of 13 (23.1%), they do 116 IVGs a year (2 a week) and have the longest waiting times in Italy. In both regions the RU486 is not used or is clearly below the national average. In a recent analysis in Turin of the four hospitals in the city, it emerged that non-objecting gynecologists are 64 (42.5%) out of 137 and that 91% of abortions are carried out in the largest hospital, where there is a specific ward. In this hospital the non-objectors are 31 (40.5%) out of 80. The male are 8 (23.5%) out of 26 and the female are 23 (50%) out of 46. The conclusion is that the potential limits for access to abortion in Italy, more than in conscientious objection depend on the organization of the service.

Contraception

P.04

How common is spontaneous pregnancy after IVF Livebirth? Systematic review and meta-analysis

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Background - It is widely known that some women having IVF go on to conceive naturally. This reproductive history is of media interest and often described as “miracle” pregnancies. Women with this experience also identify themselves as a rarity and their subsequent pregnancies include rapid-repeat, unplanned pregnancies.
Objectives - To identify, appraise and synthesise the current evidence on the rate of spontaneous pregnancy after successful IVF to support women having babies via IVF to plan and space their future pregnancies optimally.
Method - Ovid Medline, Embase and PsycINFO were searched on 24th September 2021 using a strategy containing thesaurus and free text terms for the concepts of spontaneous pregnancy, assisted reproduction and livebirth. The search was limited to English language, human studies and publications from 1980. Searches were undertaken of the Cochrane library, relevant professional institution websites and reference lists of relevant studies. The results were de-duplicated and managed in EndNote, screened by title and abstract and then full text. Random-effects meta-analyses were subsequently used to produce a pooled effect estimate of the incidence of spontaneous pregnancy after IVF livebirth.
Results - 1108 distinct references were identified reducing to 54 when screened by title and abstract. On evaluation of full text 11 studies were included in this review. Studies varied widely according to methodology, population, cause of subfertility, type and outcome of fertility treatment and length of follow-up. The pooled estimate for the rate of spontaneous pregnancy after IVF livebirth was 0.19 (95% CI, 0.16-0.22).
Conclusions - Current evidence suggests that spontaneous pregnancy after IVF livebirth is not rare, affecting at least one in five women in the first three years after having a baby via IVF. This should be used to counsel women to inform their decision-making regarding the timing and mode of conception of future pregnancies and contraception use after successful IVF.

P.05

Supporting financially vulnerable women with free-of-charge LARCs after termination of pregnancy in the Netherlands in 2020: an observational retrospective study.

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Objective - Yearly 31.000 terminations of pregnancy (TOP) are performed in the Netherlands, a third of TOPs is recurring. A new regulation enables abortion clinics to offer financially vulnerable women a long-acting-reversible contraceptive (LARC) free-of-charge, after a TOP. The LARCs available were four types of Cu-IUDs (T-Safe®, Multi-Safe®, IUB Ballerine® and Flexi-T®), two types of LNG-IUDs (Mirena® and Kyleena®) and the ENG-implant (Implanon NXT®). The objective of the study was to identify which type of LARC women chose after TOP, including financially vulnerable women, and their characteristics.
Design - The observational retrospective study was performed in Vrouwen Medisch Centrum (VMC), an abortion clinic in the Netherlands. Collected data include: age, type of TOP, parity, repeat TOP, financial status, type of LARC chosen and adverse events.
Methods - Women were counseled on contraceptive choice. The LARC was inserted either immediately after a surgical TOP or 4-6 weeks after a medical TOP. Immediately after insertion, the position of the IUDs was verified by ultrasound. After 6 weeks women were invited for another ultrasound check-up.
Results - Of the 1603 women who had a TOP, 455 women chose to have a LARC inserted. The mean age was 29 years old and over half was nulliparous (51,6%). Most LARCs were inserted after surgical TOP (70,3%). Women most often chose the hormonal IUD Kyleena (31%) or the copper IUB Ballerine (30,8%). Approximately one in ten women chose the implant IMPLANON NXT (9,5%). No statistical differences were found in expulsions or pregnancies with the IUDs. 48 women were offered a LARC free of charge, almost half of these women had a repeat TOP (47,5%) illustrating the need for access to contraception.
Conclusions - Removing (financial) barriers to reduce repeat TOPs, improves women's access to LARCs, contributing to their sexual reproductive health.

P.06

"Do you want another baby after this?": How midwives discuss contraception with pregnant and postpartum women

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Background - Discussing contraception is considered part of midwives' scope of practice in Australia, yet most midwives receive minimal training in conducting these discussions. There is a lack of guidance available in Australia on how and when midwives should discuss contraception, and little is known regarding midwives' experiences.
Methods - As part of a study of midwife-led provision of contraceptive implants, we conducted semi-structured interviews with 13 hospital-based midwives and discussed their experiences of providing

contraception information.
Results - Midwives perceived that most women found discussing contraception with a midwife to be highly acceptable, including those from cultural or religious backgrounds that may be stereotyped as being uninterested in contraception. Despite this, several midwives stated that due to the busy clinical environment, they tended to prioritise speaking to women they viewed to be most interested in postpartum contraception, including those of high parity, who had an unintended pregnancy, or were experiencing financial disadvantage or psychosocial stressors. Midwives' approaches to initiating contraception discussions varied widely. Most favoured introducing contraception into wider conversations about pregnancy spacing and women's plans for the future, in order to establish rapport and provide context to the discussion. Midwives felt that more than one conversation was necessary to allow women to consider the information before making a decision.
Conclusion - Most women appear to be open to discussing contraception with a midwife, and midwives are able to use different strategies to integrate these conversations into their practice. However, many women may still miss out on contraceptive information due to time pressures faced by midwives and cultural stereotypes that influence which women they prioritise for these discussions. National guidelines are needed that incorporate provision of contraception information as part of core midwifery practice, as well as provision of training and strategies to initiate and tailor contraception discussions to meet individual needs.

P.07

INFLUENCE OF INDUCED ABORTION ON WOMEN'S CONTRACEPTIVE USE

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Background - In France, approximately 220,000 abortions are performed every year since 3 decades despite 92% of women of childbearing age used a contraception in 2016. While access to contraception continues to improve, recourse to induced abortion is not declining in France.
Objectives - Comparison of contraceptions used before and after an induced abortion to evaluate its influence on women's choice of contraception.
Method - Quantitative study conducted in 3 family planning and abortion centres of the Paris region during 2021.
Data collected via an anonymous paper-based questionnaire filled out by women during a pre-abortion consultation.
Inclusion criteria:
Woman who volunteered and consented to participate
French-speaking woman requesting an induced abortion
Fertile woman between 18 and 49 years old
Results - 167 questionnaires were collected but 9 were excluded because of missing answers.
The rate of women not using any contraception dropped drastically from 22.8% pre-abortion to 4.4% post-abortion. IUD use increased from 3.2% pre-abortion to 47.5% post-abortion. 81.6% of women decided to change their contraceptive method to one more suited to their lifestyle. 81.6% of women were very satisfied with the information given by the doctor or midwife about contraception. 94.3% of women took an active part in the choice of contraception. A prescription pattern persists in which young women under 20 years of age predominantly used the pill or condoms (58.8%) while women over 25 years of age preferred a LARC (65.4%).
Conclusions - Contraceptive counseling at the time of induced abortion enables a contraceptive shift towards more efficacious methods. Most women in our study decided to change their contraceptive method to one more suited to their lifestyle and potentially more efficacious.
Thus, addressing the issue of contraception during an abortion process could help reduce the

number of induced abortions in the future by enhancing women's knowledge of and compliance with their contraception.

P.08

Hormonal contraception and the risk of depression

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Background - Recently, three large-scale epidemiological registry-based Scandinavian studies examined the association between use of different types of hormonal contraception and the risk of developing depression or use of antidepressants. They reached surprisingly divergent results.
Objectives - The aim of this study was to examine why these three recent studies from Denmark and Sweden could achieve quite different results, interpretations, and conclusions.
Methods - The three studies were examined according to chosen design, exclusion criteria, methodological choices, included confounders and the interpretation of the results.
Results- First, the assumption that differences between studies are due to residual confounding is proven unlikely, already because confounder control beyond age, year and education rarely change estimates materially. Rather, differences in selection of study groups, exclusions from the study groups, exposure definitions, and chosen reference populations explain the result differences between the studies. Important differences in interpretations of the results also points to different ideological views in the different (senior) research teams of the three studies.
Conclusions - The detailed review of the three Scandinavian studies reveals methodological choices as the main explanation for their different findings. Residual confounding was unlikely to explain the divergent results, while ideological circumstances might have a main responsibility for the different chosen methods and for the interpretation of the results.

P.09

Assessing a new intrauterine device insertor

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Objectives - Despite the proven benefits, including affordability and efficacy, IUD technology suffer from a lack of innovation since decades. Current insertion procedure is complicated and issues persist, including pain, risk of pelvic infection and uterus damage. Recommendations to improve the procedure fail to meet the expectations of both women and providers, especially for the pain management. There is a true medical need not met by the IUDs currently on the market.
Methods - In a pilot proof of concept study, we performed ex vivo and in vivo to test a new IUD device composed of an innovative insertor allowing the IUD insertion without using a tenaculum. The procedure was tested on extirpated uteri and patients by a trained provider not familiar with the technology and followed immediately by an ultrasound evaluation to assess the location and fundal placement of the IUD. Provider and patients also completed satisfaction surveys.
Results - The results demonstrated the ability of this new device to access and easily pass the cervix without using a tenaculum and to deploy the IUD into the uterine cavity with a correct fundal placement. Provider and patients feedback showed a high acceptability and improvements of the procedure were noticed.
Conclusions - On the strength of these encouraging results, further clinical cases study with a larger panel of providers and patients will be initiated to investigate deeper the impact of this innovative device on the ease of the IUD insertion procedure and the comfort of the patient.

P.10

INTEREST OF PREGNANEDIOL GLUCURONIDE TO PREVENT RISK OF UNWANTED PREGNANCY: A LITERATURE REVIEW

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Objectives - The present literature survey reviews the scientific relevance of detecting the overrun of the urinary progesterone metabolite, pregnanediol glucuronide (PdG) threshold as a mean to prevent the risk of unwanted pregnancy.
Methods - A thorough literature search was conducted on Pubmed and Science Direct in order to answer the following question: In healthy women of reproductive age and with regular menstrual cycle, can the overrun of a PdG urinary concentration threshold confirms ovulation and could be used to prevent pregnancy? Among the 430 retrieved articles, 54 were considered relevant and included in the review.
Results - This review shows that an increase of PdG urinary secretion is strongly correlated with the start of the luteal phase. It indicates that different methods of measuring PdG lead to different thresholds which are nevertheless highly correlated between them. Each method allows to identify the begin of luteal phase. Among the reported PdG values, values above 7 µmol/24hr or 5µg/ml indicate that ovulation has taken place at least 24-48 hours earlier. Therefore, this PdG threshold can be used as a marker of the closure of fertile window.
Conclusions - PdG measures constitute a convenient target for detection of the non-fertile phase of the menstrual cycle and therefore can be used for reliable natural contraception methods.

P.11

Quality Family Planning Services and Referrals in Community Pharmacy: Expanding Pharmacists' Scope of Practice: A protocol for the ALLIANCE stepped-wedge trial

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Background - Barriers to accessing effective contraception is experienced by women, especially by those seeking emergency contraception (EC) or early medical abortion (EMA) who are at higher risk of unplanned pregnancy. Since 2004, community pharmacists in Australia have been dispensing EC over-the-counter. Approximately 10% also dispense EMA and are well placed to provide contraceptive counselling during these dispensing conversations, but lack necessary training, suitable referral pathways, and remuneration to do so. ALLIANCE will determine whether pharmacist provision of patient-centred, effectiveness-based contraceptive counselling, in a billable consultation increases use of effective contraception and reduces unintended pregnancy amongst women seeking

EC or EMA. Methods - A pragmatic stepped-wedge cluster randomised trial across three Australian states. ALLIANCE participating pharmacies will need to have a private consultation room. Women purchasing EC or medical abortion medicines will be offered contraceptive counselling and referral to contraceptive providers when appropriate. Pharmacists will be supported through: online education, academic detailing (co-designed with consumers and pharmacy stakeholders), assistance identifying referral pathways, peer-support through AusCAPPS online community of practice and remuneration. Women will complete an online survey at baseline, four and 12-months post-consultation and 20 pharmacists and 20 women will be interviewed regarding their experiences of participating.
Results - The primary outcome is self-reported use of effective contraception four months after EC or EMA. Secondary outcomes are rates of unintended pregnancy, abortion and continued contraceptive use at 12-months, and intervention cost-effectiveness. The process evaluation will seek to understand “what worked, for whom, in what circumstances, and why.”
Conclusion - ALLIANCE, if successful, will equip community pharmacists with resources, networks, knowledge and skills to offer and deliver contraceptive counselling to women at increased risk of unplanned pregnancy. This will increase uptake of effective contraception after EC and EMA and should lead to fewer unintended pregnancies for women, thereby addressing a key Australian government priority.

P.12

Increasing the uptake of long-acting reversible contraception in family practice: results of the 3-year follow-up of the Australian Contraceptive ChOice pRoject (ACCORd) cluster randomised controlled trial

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Background - Use of long-acting reversible contraception (LARC) in Australia is low with 1 in 4 women having an unplanned pregnancy in the last 10 years. We previously reported how the Australian Contraceptive ChOice pRoject (ACCORd), a cluster randomised controlled trial of a complex intervention involving training family physicians (FPs) in effectiveness based contraceptive counselling and providing them with access to rapid referral pathways for LARC insertion, achieved increased LARC uptake at 1, 6 and 12-months.
Objectives - To assess the longer-term efficacy of the ACCORd intervention at achieving sustained LARC uptake and reducing unplanned pregnancy and abortion.
Methods - Longitudinal 3-year follow-up survey of ACCORd trial participants (women consulting ACCORd FPs). The primary outcome was the continuation rate of LARC compared with non-LARC methods. Secondary outcomes included contraceptive method used, satisfaction with contraceptive choice, and number of unintended pregnancies and abortions. Data analysis utilised logistic regression models with generalised estimating equations and robust standard errors to account for clustering.
Results - 75% (N=531) of women participating in the original trial took part in the 3-year follow-up study. Continuation rate of LARC methods was significantly higher than non-LARC methods (66% and 55% respectively p=0.027). Satisfaction with method of contraception was higher among LARC users

compared to oral contraceptive pill users. A greater proportion of intervention versus control group participants were still using LARC methods 3 years post-intervention (41% and 28% respectively p=0.019). Women in the intervention group also had significantly fewer unintended pregnancies (3.1% vs 6.3%; odds ratio=0.38 (0.16, 0.86) p=0.021) and abortions (0.9% vs 3.6%; odds ratio=0.10 (0.02, 0.50), p=0.0051).
Conclusion - Training FPs in effectiveness-based contraceptive counselling and providing rapid referral pathways to LARC insertion results in both sustained LARC uptake and reduced unintended pregnancy and abortion. Consideration should be given to broader implementation of this family practice focused intervention.

P.13
Meeting Contraceptive Preferences: A Counterfactual Analysis of Low-Income Postpartum Women in Texas

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Background - Many Texas women do not use their preferred contraceptive method following delivery. Among low-income women, there is substantial unmet demand for tubal ligation and long-acting reversible contraception.
Objectives - We aimed to identify how many rapid repeat births might be postponed or avoided if women could access their preferred method by three months after delivery.
Methods - We conducted a prospective cohort study of low-income Texan women who delivered a liveborn child at one of eight hospitals in six different cities and were publicly insured or uninsured at the time of delivery and who wanted to delay childbearing >= 2 years. Recruitment was in the hospital after delivery. Subsequent interviews were at 3, 6, 12, 18 and 24 months postpartum. In each, we asked about both preferred method of contraception as well as the method the respondent was using. We also recorded reports of any pregnancies and their outcomes. Using the iterative proportional weighting, we analyzed the risk of a pregnancy of 12+ weeks gestation among a cohort of 1441 women who wanted to delay childbearing >= 2 years. We compared the pregnancy survival curves for women who accessed their preferred contraceptive with those who did not.
Results - We found cumulative pregnancy rates more than twice as high among women who had not accessed their preferred method by three months postpartum compared to women who had accessed their preferred method by three months.
Conclusions - Whether or not a woman is using her preferred method of contraception can have a substantial influence on the likelihood of having a rapid repeat birth. We advocate expanding current definitions of unmet need, reproductive autonomy, and quality of care to include method preference.

P.14

KNOWLEDGE OF FRENCH ADOLESCENTS ABOUT ORAL CONTRACEPTION FAILURE

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Background - In France, oral contraception (OC) is used by 60.4% of sexually active women between 15 and 19 years of age (Baromètre Santé 2016). However OC misuse is high in adolescents, potentially leading to unintended pregnancy (UP). In case of missed pills, there are several back-up solutions such as emergency contraception (EC), widely known (97.5%) and used by 21.6% of teenagers.
Objectives - Evaluation of the knowledge of French teenagers of OC failure situations, and of

remedial actions to avoid an unwanted pregnancy.
Method - Quantitative study conducted in two high schools of suburban Paris during 2020.
Data was collected via an anonymous questionnaire self-administered by high school students of both genders. Students were probed on 5 potential situations at risk of UP (missed pill) and how to remedy them.
Results - 230 questionnaires were collected but 4 were excluded because of missing answers. Sample size for analysis: 226 students, predominantly female (n=177).
Only 30% students attended 3 or more sex education sessions throughout their past school life.
Overall 53.3% of participants could recognize a situation at risk of UP in case of a missed pill (no statistical difference between genders). However only 7% could state all possible remedial actions.
Levonorgestrel EC pill was mostly known by students (76%) and how to obtain it free-of-charge in pharmacies (85%) or via the school nurse (70%). Only 9.5% of students could give all correct answers and 29% of students knew its time limit. EC with copper IUD was known by only 18.7% of students.
Conclusions - Despite OC being preferred by teenagers, their knowledge of remedial actions in case of a missed pill remains too low and might explain contraceptive failures. More sex education sessions at school and additional means of adequate counseling should enhance contraceptive compliance and lower the rate of UP in adolescents.

P.15

Use of contraception and knowledge about its different methods among Latvian women

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Background - Lack of knowledge on working principles of contraceptives can affect their use. The aim of this study was to assess the current situation with the use of and knowledge on contraceptives in Latvian women.
Methods - Women were enrolled in the study using digital engagement platform equipped with a dynamic e-consent. Women were asked to answer the online questionnaire about their currently used contraceptive methods, their experience with them, and reasons to use/not to use other methods. Descriptive statistics was performed to evaluate the answers.
Results - Of 1568 women (mean age 27.0 years, range 14.0-68.0) that participated in the study, most had a normal body mass index (mean 23.9 kg/m2) and did not smoke (68.0%). Sexually active were 98%, and 79% didn’t plan pregnancy. Most of women (40.2%) used interrupted intercourse, 31.9% used condoms regularly and another 19.0% used them irregularly. Combined oral contraception (COC) was used by 21.3% of participants, and 7.5% used intrauterine devices (IUD). Most of women (63.0%) used in the past another method of contraception, and 59.0% of women think to change the method of contraception in future. Women that prefer not to use COC anymore mostly mentioned adverse events as a reason for it (41.5%). The most frequently considered methods for the future were IUD (42.9%), COC (32.4%), condoms (12.8%), or subdermal implants (11.3%). Main reasons for not choosing COC were a fear to gain weight (55.1%), to forget the regular intake (53.8%), or worries about the intake of hormones (40.8%). Other reasons to avoid COC were a possibility of mood changes (35.3%) and irregular menstrual cycle (28.7%).
Conclusions - Women in Latvia inadequately use all forms of contraception and rarely use long-acting reversible contraceptive methods. More efforts must be considered to address women's misconceptions and fears about safety of long-term contraception.

P.16

Women with normal and elevated body mass, who use levonorgestrel-releasing intrauterine system for contraception – Are there any differences of serum hemoglobin and ferritin levels after one year of follow up?

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Objective - To analyze if body mass impacts iron status and find out the prevalence and nature of iron deficiency in women with normal and elevated body mass, who use LNG IUS as a contraceptive method.
Design - Prospective non-randomized open-label trial.
Sample - 33 women who started to use the LNG IUS for contraception in 2012 and 2013 in I. Vasaraudze´s Private Clinic Ltd.
Methods - The participants were split into two groups, depending on their BMI. There were 19 women in the LNG IUS I, with a body mass below 25. The other group LNG IUS II consisted of 14 women with a body mass above 25. Serum hemoglobin level above 120 g/L was considered to be normal (non-anemic); the level below 120g/L was considered to be low (anemic). Serum ferritin level was not normal when below 15ng/mL(iron deficiency), but when the level was above 15 ng/mL it was considered to be normal.
Results - When starting to use contraception, 22% of women were diagnosed with anemia and 28% with severe iron deficiency. After six months, statistically significant difference in S-Hb level increase was found in both S-Hb <120 subgroups - for users of LNG IUS I (+20.2; $p=0.01$), for LNG IUS II (+21.1 g/L; $p< 0.05$). It was found that S-Fe increased by +17.58; $p=0.01$ LNG IUS in group I but dropped by - 8.45; $p= 0.50$ in LNG IUS II group.
After 12 months in group LNG IUS I subgroup AS-Fe grew by 11.00, but in LNG IUS II subgroup it continued to drop by - 1.07 ng/mL. While S-Hb reached a normal level in both LNG IUS groups and subgroups.
Conclusions - Iron deficiency anemia among women with different BMI can be cause by different reasons. It should not be explained only by the menstrual bleeding patterns.

P.17

PPIUCD UPTAKE AND INFLUENCING FACTORS: A STUDY OF WOMEN GIVING BIRTH AT R-FPAP CLINICS IN PAKISTAN

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Background - PPIUCDs are provided in the first 48 hours after birth. A comprehensive approach to reproductive and child health care must be implemented to guarantee a healthy pregnancy and safe delivery for women. Educating mothers on safe reproductive child health is the only way to reduce infant and maternal mortality. 54% of unintended pregnancies in Pakistan are terminated unsafely. 34%-36% of women use contraception, whereas 18%-22% have unmet needs. Even women on HIV therapy may use it without negative effects. Objective - To determine whether or not postpartum women at R-FPAP clinics in Pakistan were using PPIUCD. To investigate its acceptance, knowledge, attitudes and denial reasons. Method - A total of 357 women delivering at 12 clinics were selected as research respondents through systematic random sampling by following the delivery record register at each clinic. Findings: The PPIUCD uptake was 63% and majority among those housewives were less likely to prefer PPIUCD after delivery as compared to those having jobs. The qualification status and partner approval significantly impact its uptake. Women giving normal birth were more likely to opt for postpartum IUCD as compared to women who had C/S for delivery. Furthermore, knowledge

about postpartum family planning and women's attitudes were positively correlated (r=92, $p<0.05$), and the linear regression between knowledge and attitudes toward PPIUCD reflected a significant association. The women with good knowledge were more likely to share favorable attitudes towards PPIUCD. The major reasons for not accepting PPIUCD after delivery were partner/family disapproval, myths about becoming infertile, and fear of side effects. Conclusion: SRH education for married couples, training of health providers especially at government hospitals, and availability of the PPIUCD services is recommended to improve the postpartum family planning uptake.

P.18

Why do Albanian youth forgo methods of contraception? A multi-methods assessment of knowledge, awareness, experiences, and landscape

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Background - Youth in Albania are initiating sexual activity at an earlier age. However, use of all forms of contraception has significantly declined in the last decade and uptake now stands at 4%; the self-reported prevalence of sexually transmitted infections (STIs) and STI symptoms has risen dramatically.
Objectives - Through this study we aimed to understand the challenges that youth face in Albania when seeking sexual and reproductive health (SRH) care.
Methods - In 2021, we conducted an online survey with 273 youth in Albania. We also reviewed documents and policy, conducted 14 in-depth interviews with youth to explore their experiences with accessing SRH services, and completed 15 key informant interviews to explore the current landscape of youth-friendly SRH services in Albania.
Results - Albania lacks comprehensive sexuality and sexual health education and lack of knowledge, misinformation, and misconceptions about SRH are common among youth. Indeed, only half of survey participants had ever received any information related to birth control, contraception, or family planning, and most youth had never used any form of contraception. External condoms and withdrawal were the most commonly reported pregnancy prevention strategies; uptake of other contraceptives was basically non-existent. Health care providers lack adequate training to provide youth-friendly services and medically accurate evidence-based resources for youth are limited.
Conclusions - Changing health behaviours, lack of education, and lack of resources place Albanian youth at high risk of unintended pregnancy and STI acquisition. Educational and health systems in Albania appear unresponsive to the growing and evolving youth SRH needs. Additional educational and service delivery efforts are warranted.

P.19

SPERMICIDES RENAISSANCE: In the light of a new international study on benzalkonium chloride

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Background - Contraceptive needs change as women get older and methods that were not ideal at younger ages may become suitable. Female barrier methods such as spermicides may be adequate

for women aged 40 and over seeking alternative to pills and contraceptive devices, and also for those with episodic sexuality. However, to date, no spermicide has specifically been evaluated in late reproductive years of women.
Objective - The BZK40+ study aims to determine the efficacy of a benzalkonium chloride-containing spermicide as contraceptive among women aged 40 and over.
Methods - This phase IV, multicenter, open-label, single-arm study has been conducted in 7 private gynecologist-obstetricians in France and 6 gynecology-obstetrics clinics in Russia. 151 fertile women aged ≥ 40 (mean age: 45.9) who had a contraindication or intolerance to other contraceptives or who did not wish to use them were enrolled. They were instructed to systematically use Pharmatex® cream spermicide before each intercourse. The primary endpoint of this study was the Pearl Index (PI) over up to 12 months (typical use). Secondary endpoints were global satisfaction, acceptability and safety outcomes.
Results - The typical-use PI over up to 12 months was 0 (no unintended pregnancy) in the FAS (Full analysis set) population (n=151, 1249.7 women-months at risk). The upper 95% CI limit (2.88) was well below the hypothesis value of 22 (rate of failure of spermicides in overall population according to the French National Authority for Health). So, for the first time, efficacy of spermicides in women ≥ 40 years has been established. More than 99% of satisfaction ratings were at least good, and 96.1% of women found the lubricating effect of Pharmatex® cream appropriate. No serious treatment-related adverse event was reported.
Conclusions - Benzalkonium chloride spermicide (Pharmatex®) seems an effective, well tolerated and well accepted in women aged 40 years seeking an 'on-demand' contraception.

Counselling

P.20

Increasing uptake of long acting reversible contraception with structured contraceptive counselling; a cluster randomised controlled trial (The LOWE trial)

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Background - Different kinds of interventions introducing structured contraceptive counselling have been evaluated, most of them resulting in higher uptake of long-acting reversible contraceptives (LARCs) and lower pregnancy rates. However, interventions have failed to reduce pregnancy rates post abortion. Objectives - We aimed to evaluate the effect of a structured contraceptive counselling intervention on the uptake of LARCs and pregnancy rates.
Methods - A cluster randomised trial was conducted in abortion, youth and maternal health clinics in Stockholm, Sweden. Sexually active women aged ≥18 years without a wish for pregnancy seeking abortion and/or contraceptive counselling were included. For participants in clinics randomised to

intervention, trained healthcare providers implemented a study-specific intervention package designed for structured contraceptive counselling. Participants in the control clinics received routine counselling. The primary outcome was choice of LARCs at first visit. Secondary outcomes were LARC initiation at 3 months and pregnancy rates at 3 and 12 months. We used logistic mixed-effects models with random intercept for clinic to account for clustering. Results- From September 2017 to May 2019, 28 randomised clinics enrolled 1364 participants. Analyses including 1338 subjects showed that more participants in the intervention group compared with the control group chose LARCs: 267/658 (40.6%) versus 206/680 (30.3%) (OR 2.77, 95% CI 1.99–3.86). LARC initiation was higher in the intervention group compared with the control group: 213/528 (40.3%) versus 153/531 (28.8%) (OR 1.74, 95% CI 1.22–2.49). At the abortion clinics, the pregnancy rate was significantly lower at 12 months in the intervention group compared with the control group: 13/101 (12.9%) versus 28/103 (27.2%) (OR 0.39, 95% CI 0.18–0.88).
Conclusions - Structured contraceptive counselling increased LARC uptake in all clinics and significantly reduced unintended pregnancy rates in abortion clinics at the 12 months follow-up.

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Education

P.22

Strategies for Implementing Abortion Curricula at Community-Based Medical Schools in the United States

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Project Background - We aim to provide a blueprint for developing an abortion curriculum in the setting of community-based medical school education.We intend to evaluate medical students' perception of abortion education in the context of population-need at a community-based medical school in Washington, with the goal of providing comprehensive abortion education to future physicians. We hope to create a widely applicable framework for the development of abortion curriculum.
Methods - A survey will be utilized to assess the attitudes of medical students toward abortion care and abortion education, and to identify the level of student interest regarding reproductive health care. Second, we will analyze the reproductive content provided in years 1-4 at our medical school. We will conduct a literature review of abortion curricula at existing medical school programs and review our community's abortion needs. This will identify the reproductive educational needs of medical students and establish core competencies for an elective reproductive course. Using the information gathered, we will extrapolate a framework for other medical students to utilize this methodology for development and implementation of abortion curricula.
Results - We are in the early stages of our project. Our deliverable outcomes will include the development and analysis of surveys, literature and epidemiological reviews, and the framework for developing and implementing abortion care curriculum based on our methodologies.
Conclusion - Abortion is a common procedure that is insufficiently covered in medical school education. This leaves future physicians at a loss of knowledge for a medical procedure that many of them will undoubtedly encounter–creating space for medical error, misconceptions, and increased

patient risk. Medical schools have the unique opportunity to provide abortion and miscarriage care curricula to future doctors prior to specialization. A blueprint for the development of abortion curricula will address the lapse of education on abortion currently available at medical schools.

P.23

Stories of Abortion in The Abstinence Project: Exposing the harms of abstinence-only sex education through the art of storytelling for people seeking abortion care

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Background - Sexual health education is deficient across many parts of the world. There is ample evidence to support the link between access to sexual health education and unintended pregnancy. In the USA, only 18 states require medically accurate information and abstinence-only sexual health education reigns supreme in many states. Abortion legislation is actively moving through many abstinence-only states, limiting or eliminating access to abortion. As access to safe abortion narrows, this makes accurate sexual health education even more important. Utilizing the art of storytelling provides a level of personalization that can be empowering for self and others.
Objectives - To further understand the link between the harms of abstinence-only sex education and the experience of abortion using the compelling power of the art of storytelling.
Method - Data were obtained from stories about the harms of abstinence-only sexual health education specific to the experience of abortion that were submitted to The Abstinence Project (N = 42). These qualitative data were analyzed using reflexive thematic analysis to identify themes in the data that provide insight into how abstinence-only sex education has perpetuated shame and stigma around abortion.
Results - In the 42 stories shared with The Abstinence Project related to abortion, there were 5 themes identified in the data that provided insight into the link of abstinence-only education to abortion care. These themes included: 1) knowledge gaps, 2) secrecy and shame, 3) psychological distress, 4) abortion timing and safety, and 5) motivations for advocacy.
Conclusions - Developmentally appropriate, medically accurate, inclusive, comprehensive sexual health education is crucial, especially as access to abortion narrows. By sharing stories we empower ourselves and others. Abstinence only sexual health education is particularly harmful for people who seek abortion care; this is important for clinicians offering abortion care and better sexual health educational practices are crucial to address this issue.

P.24

Education: A critical component in saving women's lives from abortion related deaths

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Background - Abortion is a taboo topic in Zimbabwe. Abortion in Zimbabwe is governed by the Termination of Pregnancy Act (1977). The law allows abortion if the pregnancy is a result of unlawful sexual intercourse, rape or incest, if the health of the mother is in danger, or in case of severe fetal anomalies. A 2016 Guttmacher Institute study revealed that more than 65,000 abortions happened that year. There is a post abortion care programme where women can access services. Abortion complications are the fifth contributor to the high maternal mortality rate which currently is at 462 deaths per 100,000 live births.
Objectives - Women's Action Group (WAG) realised that community members and policy makers, mainly members of parliament (MPs) and health workers were not aware of the provisions of the law. WAG initiated a three-year awareness programme on the law targeted at community members

and policy makers and health workers.
Methodology- WAG developed fact sheets, conducted workshops, dialogues and advocacy meetings. Value clarification exercises from the IPAS toolkit were used, targeting 60 policy makers and 1000 community members. WAG recorded stories of change. Eighty health workers trained on the Abortion Act.
Results - Levels of awareness were increased and currently abortion stigma is reducing. Women who have had unsafe abortion are being referred to health centers for post abortion care. Sixty-five abortion referrals were made over 2 years. There has been a shift in abortion stigma. Three MPs mentioned abortion in parliament, 60% health workers showed positive attitudes. Advocacy work for the review of the current law on abortion is continuing.
Conclusion - It is important to educate communities, policy makers and health workers on access to safe abortion in order to increase referrals and reduce abortion stigma.

P.25

INTEGRATION OF FAMILY PLANNING TRAINING INTO US OBSTETRICS AND GYNECOLOGY GRADUATE MEDICAL EDUCATION

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Background - All U.S. obstetrics and gynecology residency programs are required to include routine abortion training, and individual residents are permitted to opt out of doing abortions. The U.S.-based Kenneth J. Ryan Residency Training Program in Abortion and Family Planning (RP) was founded in 1999 to support ob-gyn residency programs to integrate family planning training and encourages all residents to participate to their comfort level in training. As of May 2022 the Ryan Program has supported 105 U.S. programs to integrate training in contraception and abortion care, including counseling, ultrasound, first-trimester manual and electric uterine aspiration, and second-trimester dilation and evacuation.
Objective - We sought to describe the current status of abortion training in these programs.
Methods - Faculty RP directors complete an annual survey, with 92 qualifying programs surveyed in 2021, and residents complete a post-rotation survey. We analyzed quantitative data using STATA.
Results - As of May 1, 2022, a total of 3,099 residents in 96 ob-gyn programs completed post-rotation surveys (response rate of 72%). 82% fully participated, and 18% partially participated in training. During the rotation, residents – including those who only partially participated – gained skills in first- and second-trimester abortion care. Overall, residents did a median of 11 medication abortions, 14 first-trimester manual and 19 electric aspiration abortions, and 8 dilation and evacuation procedures. Eighty-one percent intended to provide abortion care for some indications and 61% for all indications in their post-residency practice. More than ninety percent of residency program directors (97.5% response rate) reported that training improved resident competence in abortion and contraception care.
Conclusion - Integrated abortion training gives ob-gyn residents the skills and inspiration to provide comprehensive reproductive health care, including uterine evacuation and abortion care, in future practice.

P.26

Role of sexual education on intentional abortion rate in Iran

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Background - The lack of sex education (due to the religious beliefs in traditional population) is palpable in Iran, which has led to social problems and medical issues.
Objectives - The propose of this study was to investigate the role of lack of sex education in the rate of the sexual problems and induced abortions in the last 25 years in Iran.
Method - This retrospective study was designed according to data collection through official statistical data from Legal Medical Organization and Statistical center of Iran during 1996-2020.
Results - Due to the lack of sex education for general population, society's sexual knowledge is very limited. Sexual health and family planning training have been deleted in the universities. The prevalence of female and male sexual dysfunctions were 67.9% and 58.2%, respectively. Overall prevalence has been increased significantly in recent years. Only 1.4 % of induced abortion were legally licensed during this period. The majority of induced abortions are due to unwanted extramarital pregnancies. According to the law, pregnancy outside the marriage is an unforgivable crime in Iran. Considering with 25% decrease in marriage rate and 4.8 fold increase in divorce rate, the rate of intentional abortion has been increased about 5 times.
Conclusions - This study can be considered a model for all similar societies. This study might suggest the importance role of public knowledge about sexual health and family planning from school to university, breaking the taboo of treating sexual problems, and its protective effect for reducing the number of intentional abortions as well as the complications of abortions.

P.27

Patient and Public Involvement (PPI) in abortion research: an exploratory survey

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Background - Patient and Public Involvement (PPI) refers to activities where members of the public/patients are actively involved in contributing to research as advisers or co-researchers. PPI has been relatively absent from abortion research. Researchers have expressed difficulty in engaging a patient population who value confidentiality and sometimes do not want to re-engage with services. Furthermore, there has been no consensus on the best term to collectively refer to people who have had an abortion in research outputs. Researchers have used the terms clients, service-users, patients, and abortion-seekers. Many have reflected on the negative connotations of each term, but few have asked people who have had an abortion what word they think should be used.
Objectives - To seek the views of people who have had an abortion on:
a) Being involved in PPI
b) What language to use when collectively referring to people who have had an abortion in research
Method - I used an anonymous survey shared on social media to ask abortion patients if they would participate in PPI and whether they had any concerns. I also asked which of the terms they prefer from clients, service-users, patients, and abortion-seekers, and asked them to suggest others.
Results - Preliminary findings (n=46) indicate 70% of respondents were interested in being involved in PPI, through either one-off or longer-term commitments. 26% said they had some concerns about being involved, including wanting anonymity. Regarding terminology, 59% preferred the term 'patient', 20% preferred 'service-user', and 7% preferred 'abortion-seeker'. No respondents selected 'client' and 15% said they preferred another term, with equal numbers suggesting 'people' or

'women having an abortion'.
Conclusions - These findings suggest a significant proportion of abortion patients may participate in PPI. Designing PPI that meets the needs of abortion patients may lead to more successful and meaningful involvement of the public/patients in research.

Emergency contraception

P.28

Community midwives' role in mitigating the effect of violence against women and girls in a humanitarian crisis: a cross-sectional, qualitative study with the National Yemeni Midwifery Association

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Background - Incidence of intimate partner violence, including sexual violence, increases during conflicts, as armed groups use sexual violence as a tool to destabilize the population. In Yemen, where 80% of the population lives in rural areas and nearly 50% of the health facility are functioning, community midwives are the only source of sexual and reproductive health (SRH) care for many women and girls. Midwives' provision of emergency contraception (EC) can protect women from unwanted pregnancy and dangerous consequences, including honor killing. In this study, we asked community midwives to tell us about their knowledge, attitudes, and practices related to women and girls who experience sexual violence.
Methods - We conducted 20 in-depth interviews with midwives who are part of the NYMA network in four Yemeni governorates. Interviews were conducted using a semi-structured interview guide in person or over Zoom by a Yemeni physician trained in qualitative research and the ethical conduct of VAWC-related research. Participants provided verbal consent for the one-time interviews. Transcriptions were analyzed by two researchers using a grounded theory approach and MAXQDA software.
Results - Midwives reported that women must consult with their husbands prior to choosing a contraceptive method, otherwise women may experience violence or threat of divorce.By providing EC to women and girls at home, community midwives help women and girls avoid the stigma associated with accessing EC through a pharmacy. While midwives had not received training on how to talk to women and girls about sexual violence, they serve a critical role, including prospective provision of EC to women and girls who experience sexual violence and care for sexual violence-related morbidities.
Conclusion - Emphasizing the role of the midwives to provide EC for victims of sexual violence is of central importance. Midwives should receive training and support to better serve women and girls who experience violence.

P.29

OB-GYNs and autonomous health movements for self-managed abortion – friends or foes? The example of a struggle in Poland.

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Self-care in abortion has gained unprecedented traction from institutionalized health systems during the pandemic. However, many of those 'innovations' have been present for decades in feminist programs on abortion access in restrictive settings (hotlines, telehealth, community care, 'no-touch' protocols).
In Poland, after the further restriction of the law in 2020, abortion is practically not provided in public hospitals. 3 women have died in Polish hospitals since, denied lifesaving abortions, because of the perceived chilling effect of the law on the doctors.
Despite the lack of practice in abortion, the gynaecologist and doctors remain in forefront of the media/public attention. In contrast, the actual activist abortion practitioners follow the best standards of care and newest guidelines, are in general unsupported by the Polish doctors, while openly supported by the WHO, human rights bodies or FIGO.
We will use auto-ethnography of two young doctors in Poland (25 and 26 years old), co-creators of the collective Doctors Pro-Abo, who support individual people through self-management and publish newest WHO protocols on social media. We will present evidence from press disputes between activists and doctors, tell about the experience of harassment and judgment of openly pro-choice doctor working in public hospitals.
The objective is to reveal the horrifying gaps in evidence-based medicine in Poland, expose the stigma among fellow doctors, to galvanize international support for training of new generation of abortion providers in Poland, as well as underline an omnipresent tension between institutionalized systems of medical practice and autonomous health movements.
One of the cornerstones of self-managed abortion (SMA) – demedicalization – remains contested in institutionalized health systems. SMA involves new actors and new paradigms for abortion care, and by shifting the locus of control, redefining "quality care" and centering of the pregnant person it fundamentally challenges traditional abortion care models.

P.30

Improving rural and regional access to long acting reversible contraception and medical abortion through nurse-led models of care, task sharing and telehealth (ORIENT): a protocol for a stepped-wedge pragmatic cluster randomised controlled trial in Australian general practice

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Background - Women in rural and regional Australia often experience difficulties accessing long-acting reversible contraception (LARC) and medical abortion (MA). Nurse-led models for these services have been successful in community health, but have not been evaluated in the Australian general practice setting.
Objectives - The primary objective is to evaluate the effectiveness of a nurse-led model of care involving provision of LARC and MA in general practice at increasing access to these services for women in rural and regional areas. Secondary objectives include evaluating the implementation of the nurse-led model and the cost-effectiveness of the intervention.
Method - The ORIENT nurse-led intervention will be delivered and evaluated using a stepped-wedge pragmatic cluster randomised controlled trial design. We will recruit 32 rural and regional general practices, enrolling ≥2 general practitioners (GPs) and one practice nurse per practice. The nurse-led model will be co-designed with healthcare providers, consumers, researchers and women's health advocates. Practices will be randomised to implement the model in a sequential manner, and supported through clinical upskilling, educational outreach with clinical experts, and engagement with professional peers through an online community of practice.
Results - The primary outcome is the change in the rate of LARC prescribing comparing control (usual care) and intervention phases. Secondary outcomes include change in the rate of MA prescriptions and telehealth services. A cost-effectiveness analysis will determine relative costs and benefits of the model, on LARC and MA prescribing rates, compared to usual care. A realist evaluation will provide contextual information on intervention implementation informing considerations for national scale-up.
Conclusions - The ORIENT trial has the potential to increase LARC uptake and access to MA for women in rural and regional Australia. Trial outcomes will contribute to national and international scholarship on improving availability and accessibility of contraception and abortion services through service delivery innovations in primary care.

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The Australian Contraception and Abortion Primary Care Practitioner Support (AusCAPPS) Network: An Online Community of Practice Protocol

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Background - General practitioners (GPs), practice nurses (PNs), and community pharmacists (CPs) are well placed to support women's access to long-acting reversible contraception (LARC) and early medical abortion (EMA). In Australia, however, few GPs and pharmacists provide this care, stating the lack of training opportunities and support and feelings of isolation as barriers.
Objectives - The primary objective is to establish, implement and evaluate an innovative, multidisciplinary online community of practice (AusCAPPS) to increase the availability of LARC and

EMA services in Australian primary care.
Secondary objectives are to:
Increase the number of EMA prescribers and dispensers
Increase rates of LARC and EMA prescriptions
Improve primary care clinician's knowledge and attitudes regarding LARC and EMA
Method - The platform's design will be informed by a knowledge exchange workshop with industry, professional, government, and non-government organisations. Then, secondary outcomes will be assessed through (1) health service data to determine changes in the number of EMA prescribers and dispensers, and LARC and EMA prescriptions; (2) pre-and post-implementation surveys to assess knowledge, attitudes, and practices; and (3) Google analytics and interviews to evaluate participant experiences of the platform.
Results - The AusCAPPS Network has been established and recruitment is underway. AusCAPPS is an interactive online community of practice for GPs, PNs, and CPs who are working in primary care to deliver LARC and EMA services. A baseline survey of GPs, PNs, and CPs has been completed. Analysis is underway and the results of this baseline will further inform AusCAPPS content.
Conclusions - We anticipate that AusCAPPS will provide networking opportunities, expert advice, resources, and education, supporting providers in best practices. AusCAPPS will demonstrate how an online community of practice can empower the primary care workforce to deliver best-practice, evidence-based care for women of reproductive age who are trying to prevent or manage an unintended pregnancy.

P.32

How are midwives and nurses trained to provide abortion care, information and support? Findings from a scoping review.

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Background - Midwives and nurses provide MVA and support for management of abortion with pills within their skills and scope of work, and are often preferred providers of support. However, there is little consensus on nurses and midwives' role in abortion.
Objective - My aim was to review published and grey literature on how nurses and midwives learn to provide abortion and post abortion care, information, and support.
Method - I conducted a scoping review in PubMed and Google Scholar. Inclusion criteria were reports and articles published since 2000 in English on nurses' and midwives' abortion training. I searched databases using keywords and included relevant referenced studies. Out of 303 articles, I removed duplicates (n=33) and non-eligible articles after abstract (n=66) and full text screening (n=54). I coded the remaining (n=89) into themes inductively.
Results - Research on abortion training for midwives and nurses is geographically global, with population-specific and universal learning experiences emerging in the literature. Key themes were 1) the value MVA and person-centred abortion care training for reasons including: financial sustainability, reducing waiting times, awareness of abortion law, to reduce provider burnout and experience of stigma, 2) individual factors that affect implementation of abortion training, including attitudes towards abortion, conceptualisation of roles and experience, 3) institutional factors, including conscientious objection, 4) policy conditions required for abortion education, and 5) the type of training required including continuous value clarification, supervised clinical placements for MVA, and client-centred counselling and referral.
Conclusions - Findings show a strong public health rationale for training of nurses and midwives on abortion care. Studies also report individual, institutional, and policy-level barriers and opportunities for abortion training and task-sharing. More research is needed on the formal and informal

information channels that resonate with nurses and midwives and change behaviours when learning about abortion in settings affected by abortion stigma.

P.33

Hormone replacement therapy - a study of postmenopausal women's knowledge, attitudes and practice in Georgia

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Objective - To determine the knowledge, attitude and practice towards Hormone Replacement Therapy (HRT) among postmenopausal women in Georgia.
Methods - A descriptive cross-sectional study based on a sample of women 45-60 years was conducted at the outpatient departments from across Georgia. 280 postmenopausal women who came to outpatient department as a patient were interviewed after taking verbal consent. Sociodemographic characteristics, knowledge and attitude towards menopause and HRT were collected through a structured pretested questionnaire. 218 women (78%) responded.
Results - The mean age of respondents was 57.3 years. The mean age at menopause was 47,7 years. Out of 218, one hundred thirty-six (62.4%) women knew about the symptoms of menopause, 17 (8%) knew about the consequences of menopause. 04 (1.8%) respondents were aware of HRT. Only 03 (1.4%) women applied for hormone replacement therapy under medical supervision and 174 (79,8. %) desired to learn more about menopause. Hormone replacement therapy was used by women primarily to treat menopausal symptoms. In general, women were correctly informed about the effects of hormone replacement therapy, but misconceptions about its side effects may indicate the need for further health education.
Conclusions - Majority of women lacked sufficient knowledge on menopause and HRT. Enhancing communication between healthcare providers and menopausal women remain the challenges in Georgia.Health-care providers, as providers of the therapy, in listening to women and helping them to make their own decision about whether or not to take hormone replacement therapy.

P.34

Adaptation and endorsement of abortion care and post-abortion care Best Practice Papers (BPPs) in low and middle-income countries (LMICs) to supplement local guidelines

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Objective - To increase the dissemination of concise clinical guidance on abortion to improve health worker knowledge and confidence to provide, develop and/or support abortion services. Background - Approximately 97% of unsafe abortions occur in LMICs and Africa has the highest burden of abortion-related deaths globally (Ganatra B, 2017). Lack of effective dissemination of guidelines and education about legal indications for and provision of safe abortion contributes to higher mortality and morbidity in these settings. Method - The BPP is a guidance document that synthesizes the evidence to develop and provide quality abortion services. OBGYNs adapt the papers by:
Identifying amendments that need to be made to suit the local context
Holding stakeholder meetings to gain consensus and validate a draft
Appointing peer reviewers
Drafting a final version for presentation to ministry of health for endorsement
Sending the national adaptation to RCOG for endorsement
Disseminating through local stakeholders including O&G society, midwifery and nursing organisations and educational institutions

Results - Healthcare professionals have access to a locally relevant and endorsed, concise and practical tool, grounded in latest evidence and best practice to support their implementation of abortion and postabortion care services.
Conclusions - The BPPs are a useful guiding tool, which can be adapted to support clinicians in LMICs to develop, tailored, locally relevant guidelines. These guidelines can increase healthcare worker knowledge and confidence in providing abortion and postabortion care and support high-quality abortion education.
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P.35

The role of health care providers in expanding the legal grounds for safe abortion: insights from Argentina, Ireland, and South Korea

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Background - In recent decades, around 50 countries have liberalised their abortion laws, either under specific circumstances or on demand. The road towards the expansion of the legal grounds for safe abortion is a long, highly sensitive, and very difficult process which includes many stakeholders. While health care professionals have been recognised as key health advocates, their specific role in influencing abortion law reforms has been scarcely studied. Limited insights into this potential role of health care professions can hinder their effective mobilisation in the field.
Objectives - The objective was to better understand and identify what can be the role of health care professionals and organisations in national initiatives aiming to expand the grounds for legal abortion focusing on three countries that recently liberalised their legal and regulatory abortion frameworks: Argentina, South Korea and the Republic of Ireland.
Method - This research was an exploratory qualitative multimethod study. First, a systematic literature review was completed to synthesise research findings on the role of health care professionals in (advocacy) efforts to expand grounds for legal abortion worldwide. Following this, a desk review and key informant interviews were conducted for each focus country.
Results - In all countries it was perceived that health care professionals did contribute to the effective law reform. The main perceived contributions included their influence of the debate in national congress, the amplification of women's experiences, the scientific credibility and trust they brought to their argumentation, the counteracting of anti-rights arguments, filling gaps in abortion narratives and the contacts and entry points with governmental bodies.
Conclusion - Health care professionals are key advocacy actors and proved vital in contributing to national efforts to reform abortion laws. For other countries who are looking to reform their abortion law, health care professionals should be included as key stakeholders to contribute to the efforts.

P.36

Learning from the Past: Pro-Choice Physician Advocacy in Ireland, 2002-2018

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In a 2018 referendum, Irish citizens voted overwhelmingly to repeal and replace the Eighth Amendment of Ireland's Constitution, which had imposed a virtual ban on abortion in the Republic of Ireland since 1983. After many years of grassroots activism and political advocacy, the campaign to repeal the Eighth intentionally framed abortion as a health issue rather than a moral one. Some of the campaign's most prominent spokespeople were physicians from Doctors for Choice, a small Irish physician advocacy group founded in 2002 to advocate for the integration of abortion into mainstream medicine. This presentation will review the findings of a recently published case study of Doctors for Choice. The study used in-depth interviews with Doctors for Choice members and key stakeholders in Irish abortion politics to analyze the organization's sixteen years of pro-choice physician advocacy. Doctors for Choice leveraged the social power of doctors, but framed abortion in terms of patient-centered care rather than physician authority. This messaging allowed the organization to collaborate with grassroots and civil society organizations in a powerful political coalition. We will consider how these findings can be utilized by pro-choice healthcare professionals to build upon the experience of Doctors for Choice - both their successes and challenges - to develop pro-choice advocacy strategies based on principles of autonomy and self-determination in healthcare.

P.37

"Falling into the wrong hands" narratives about medication abortion in English news and policy landscapes.

Emma Parnham, Queen Mary University of London, London, United Kingdom

Background - Over the past 30 years there have been normative shifts towards greater acceptance of people's ability to manage their own abortion using medication. This sped-up considerably during the COVID-19 pandemic which impelled some countries including the UK to trial telemedicine abortion. Evidence suggests that self-managed and telemedicine abortion can be safe, effective and acceptable in a wide range of contexts (WHO, 2022).
Objectives - To develop a genealogy of narratives surrounding medication abortion in the English news and media discourse.
Method - I examine the "descent and emergence" of discourse that shape policies and language around medication abortion in England using Foucault's genealogy methodology (Garland, 2014, p. 372) by analysing media and policy documents from the development of mifepristone in the 1980s to the permanent approval of telemedicine abortion 2022. Genealogy allows the researcher to let historical context work on the understanding of the present uncovering valuable insights into the emergence of 'knowledge' that we take for granted.
Results - Stigma is created where a complex phenomenon is over-simplified (Kumar et al., 2009). This simplification has resulted in two dominant archetypes of people who choose to "reject motherhood" either the vulnerable or selfish woman. Neither woman is regarded as capable to make decisions about reproduction, legitimising medico-administrative control over abortion (Sheldon, 1997, p. 44). I found evidence of these archetypes in abortion discourse in England for example, "The

problem with termination services available without access to medical oversight is that we know that women often understate their gestation." (The Guardian, 2008).
Conclusions - Medico-administrative control of abortion takes complex issues, out of the public realm and into the specialist paradigm, which delegitimises lay knowledge and expertise, perpetuating stigma and often leaving women without a voice.

P.38

MIFEPRISTONE IN ITALY IS INCREASING, NOT TOO MUCH, BUT IT IS GROWING

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Mifepristone (RU486) was authorized in Italy in December 2010 but became available from March 2011. According to the minister's annual report data, use has grown from 7.9% in 2011 to 26.5% in 2019. The number of procedures has grown from 7,708 in 2011 to 18,945 in 2019. There are regional differences ranging from 0.3% in Molise to 49.5% in Piedmont. In the same period abortions decreased from 99,336 in 2011 to 73,207 in 2019. In Italy abortions are performed in hospital, mostly in day hospital. Since August 2020 it is possible to have an abortion in a public clinic, but the experience is still sporadic. In the largest Italian hospital, the Sant'Anna hospital in Turin, which accounts for 4.2% of abortions in Italy, the percentage of medical abortions has reached 66% in 2021. Despite the greater commitment that medical abortion involves compared to surgical abortion, especially for follow up, we expect a rapid increase in the coming years as day hospital and outpatient practices increase in regional health systems.

Initiatives Politics and Society

P.39

Abortion and Contraception for People in Prison: A Scoping Review

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Background - Women are the fastest growing population in prisons in Canada and around the world. Evidence suggests women experiencing incarceration have higher rates of unmet contraceptive need and of abortion than the general public. Incarceration presents multiple potential barriers to accessing abortion and contraception care including prison security protocols, prison locations, lack of access to care providers, stigma, and low health literacy.
Objectives - To conduct a scoping review to understand the extent and type of evidence in relation to contraception and abortion access for people experiencing criminalization and incarceration.
Methods - We used the Joanna Briggs Institute methodology for scoping review. A medical librarian developed the search strategy in CINAHL and translated it for APA PsycInfo, Gender Studies, Medline (Ovid), Embase, Sociological Abstracts, Social Services Abstracts. The search was conducted in February-March 2022. All citations were uploaded into COVIDENCE. Two reviewers independently screened abstracts and titles in relation to the criteria for full-text consideration. Data were extracted from papers included in the scoping review using a tool developed by the reviewers, including details about the setting, study design, participants, sample size, procedures, outcomes of interest, and key findings.

Results - The search obtained 6095 titles once duplicates were removed. After title and abstract screening, 133 were considered for full-text assessment, and 61 were included in the review. Most studies used survey methods, focused on contraception, and were based in the United States. Outcomes of interest in the studies included prison policies governing contraception, geographic distance from prisons to abortion providers, individuals' reproductive history, past and current contraception use, pregnancy and contraception intentions, and education and knowledge about sexual and reproductive health.
Conclusions - There is a lack of research conducted outside of the US, about abortion experiences, and about interventions to improve sexual health, knowledge and outcomes. Future research should address these gaps.

P.40

Factors affecting Accessibility and Utilization of Safe Abortion Services at Public Sector Health Facilities in Nepal

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Background - Nepal has one of the progressive abortion laws that guarantees Nepalese women's rights to legal, affordable and safe abortion. Free abortion services are provided at public sector health facilities. Despite the provisions, the annual trends of abortion clients have been declining over the years. Many Nepalese women would rely upon private sector facilities and pharmacy outlets for abortion.
Objectives - The paper discusses the demand-side and supply-side factors affecting accessibility and utilization of safe and free abortion service by women for gestation up to 12 weeks at public sector facilities in Nepal.
Method - Review of reports, key informant interviews and analysis of trends in utilization of medical and surgical abortions based on national HMIS data.
Results - Since abortion service is free at all public sector health facilities, a steady increase in the trends of women seeking abortion is expected. Unfortunately, this did not resonate from the 2021 national data maintained by the Health Management Information System (HMIS) Unit of the government. Decline in the annual number of abortion clients in 2018-19 by 6,400 as compared to the 2016-17 level and by 8,600 from the 2017-18 level. Reasons for the decline in of abortion clients at the public sector facilities are: inadequate knowledge about the free abortion care, social stigma associated with abortion, and women's preference for private clinics/pharmacy outlets for abortion. The 'supply-side' factors affecting service availability were: absence of trained abortion providers, stock-out of abortion commodities, and poor coordination between abortion providers and the local government for abortion costs reimbursements.
Conclusions - Unless the government ensures the presence of trained abortion providers at all levels and strengthens coordination and monitoring of stock availability of abortion commodities, reversal of the trend would be difficult.

P.41

Norms and values related to SRHR and gender equality and their association with reproductive agency among men and women of reproductive age in Ethiopia, Kenya, Nigeria and Zimbabwe

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Sexual and reproductive health and rights (SRHR) is closely linked to social norms and values related to gender influencing individuals' ability to make choices and decisions and access information and services concerning their bodies, relationships, and fertility. The objective of this study is to investigate the association between the level of self-reported reproductive agency and norms/values related to gender equality and SRHR among women and men of reproductive age in Ethiopia, Kenya, Nigeria, and Zimbabwe. Using the World Values Survey (WVS), we collected and analysed nationally representative data on norms/values for gender equality/SRHR and reproductive agency among adults (>18 years) via face-to-face interviews in the four countries. Data was collected between 2018-2021 as part of the 7th wave of WVS. Bivariate, and multivariable analyses were performed to explore the associations between norms/values related to gender equality/SRHR and level of reproductive agency in the four countries. Data were analysed for men and women (50/50%) of reproductive age (18-50), a sample size of 4302 respondents. Most respondents reported their reproductive agency (on a 1-10 grade scale) to be high (median 8; mean 7.40; SD=2.68). We used the median to divide the respondents into two groups of reproductive agency: high (N=2,356, 55%) vs. low (N=1,946, 45%). A larger proportion of respondents who reported low reproductive agency lived in Nigeria, were women, had low levels of education and employment as well as had more than 4 children. Differences across age, marital status, and residency were not statistically significant. Preliminary results show that respondents who reported high reproductive agency, were consistently in agreement with a range of statements related to SRHR and gender equality, e.g., universal access to contraceptives and comprehensive sexuality education. Effective research and programs need to systematically consider these contextual factors to have an impact.

P.42

Medical abortion in Italy: a misunderstood revolution

Anna Pompili' Centro S. Anna, Rome, Italy, Roma, and AMICA Associazione Medici italiani Contraccezione e Aborto, Rome, Italy; Mirella Parachini[42], FIAPAC, AMICA Associazione Medici italiani Contraccezione e Aborto, Rome, Italy

Background - Mifepristone was introduced in Italy in 2009. In 2010, the Ministry of Health published the national guidelines for MToP (Medical Termination of Pregnancy), which imposed the gestational age limit of 49 days and the obligation of hospitalization until expulsion. These limitations have seriously restricted the access to this procedure. In 2020, under the pressure of the health emergency due to the pandemic, the Ministry of Health updated the MToP guidelines, extending the gestational age limit to nine weeks and admitting the procedure "at home". However, after almost two years, the possibility of accessing the procedure outside the hospital is applied in very few cases, and only in the region of Lazio women can take the second drug, the prostaglandin, at home. By contrast, in the other regions, misoprostol is administered in an outpatient setting but women are

"kept under observation" for 3 or 4 hours; often they can return home only after performing an ultrasound control.
Method - We conducted a comparative analysis of the protocols for MToP adopted in Lazio and Tuscany.
Results and conclusions - This comparative analysis shows that in Tuscany medical abortion is performed by adapting hospital models to a typically outpatient procedure. Other regions have adopted protocols similar to the Tuscany one; in this context, the difficulty of having clinics with facilities in which women have to stay for several hours is a new obstacle for women to access this procedure. It also demonstrates the difficulty of health systems to consider women as responsible persons, capable of self-managing a medical procedure. There has been a change but it requires the cultural revolution that medical abortion involves.

P.43

Advocating for Safe Abortion in West Africa: Lessons from FIGO's ASA Project in Benin

Jema Davis, International Federation of Gynecology and Obstetrics (FIGO), London, United Kingdom

Background - The International Federation of Gynecology and Obstetrics (FIGO) has been implementing an Advocating for Safe Abortion Project with 10 national member societies of OBGYNs since 2019. Four of these are in West Africa – Cote d'Ivoire, Benin, Cameroon and Mali. In 2021, the law was changed in Benin to further liberalise access to safe abortion, a notable success in a region with mostly highly restrictive laws.
Objectives - This presentation will seek to identify the impact of the advocacy activities carried out by the Collège National des Gynécologues Obstétriciens du Bénin (CNGOB) and their partners in Benin before and after the legal change, and the key learnings that can be applied to advocacy for safe abortion both in West Africa and elsewhere.
Method - A comprehensive final evaluation of the project has been conducted by external partners. Using data and findings from this, reviews of the media in Benin at the time of the vote, and direct qualitative inputs from the CNGOB and FIGO team, the presentation will specifically consider both the impact and the potential limitations of positioning abortion as a healthcare issue in the Benin context, including in management of opposition to change.
Results - The presentation will show that whilst there were a number of factors that led to the legal change, positioning access to safe abortion as a way to combat maternal mortality in Benin was an effective advocacy tactic in generating support for the change. However, it is not without limitations, not least when it comes to ensuring a genuine increase in access to safe abortion in Benin after the vote.
Conclusions - In conclusion, it will be suggested that those advocating for similar changes in the law in West Africa and beyond must consider how different positioning of the issue may impact implementation of any legal change.

P.44

RISE UP: Risk and Resilience in Unintended Pregnancy, a Life Course Perspective

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Background - The Hague is a city with one of the highest rates of perinatal mortality and morbidity as well as teenage pregnancies in the Netherlands, and midwives estimate 50% of pregnancies to be unintended. Although unintended pregnancies (UPs) have a higher risk of adverse health outcomes, not all UPs are vulnerable. Therefore, it is important to assess what combinations of risk factors

make a UP vulnerable.
Objectives - The aim of RISE UP is to improve prevention, recognition, and support of unintended pregnancies in The Hague, specifically those in vulnerable situations. The primary objectives of the study are to 1) identify factors and processes over the life course that increase risk for a (vulnerable) UP, and 2) uncover needs for care and support for people who experience a UP.
Methods - Mixed method explanatory project in The Hague: a prospective population-based cohort study using quantitative surveys linked to routine care data, and qualitative life course interviews at multiple moments during and after pregnancy. The study population includes pregnant people and their (ex-)partners.
Results - A pilot of the survey has been completed together with experienced experts and the data collection is currently in process. The interviews are in the pilot phase and will start in the second half of 2022. To connect with and facilitate connections between social and medical professionals involved in the support of pregnant women, the researchers set up an advisory group in The Hague. Furthermore, this project is part of a national learning network that aims to collect knowledge on vulnerable parenthood and unintended pregnancies in the Netherlands whilst facilitating co-learning between researchers, stakeholders, and experienced experts.
Conclusions - RISE UP is a mixed methods study that will provide knowledge and tools for professionals to improve care for people experiencing a (vulnerable) UP in the city of The Hague.

P.45

45 Barriers to abortion in Spain. It is not just to law to be blamed

Jordi Baroja, Silvia Aldavert
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12 years after the Spanish law that confirmed abortion as a woman’s right and consider it as a part of free public services, there were not many attempts to evaluate and monitor the real obstacles in accessing abortion. In 2021, the Associació de Drets Sexuals i Reproductius (Catalonian Sexual and Reproductive Rights Charity) carried out a research to highlight the main obstacles to access abortion in Spain.
A combined research methods were considered such as bibliography review (legislative framework, abortion statistical reports...), interview with key agents, webside analysis or “mistery calling strategy” to public health hotlines...
The result is a key report with 45 barriers to abortion in Spain structured in the following areas: Access to information, Legal framework, workflows and territorial inequities, choice of method and anti-rights attacks.
At least 6,400 women and pregnant people traveled in 2020 outside their province, island or Autonomous Community in order to access the voluntary interruption of pregnancy due to the lack of abortion providers (7% of all abortions).
The information offered regarding public abortion available at the official websites of the various autonomous regions in Spain is hard to obtain, with unclear language and confusing workflows. Depending on the region, a woman can access to both methods (medical or surgical) or just one, a huge disparity that questions the principle of women's choices.
In relation to fundamentalist harassment, more than 8,000 women have suffered harassment and harassment at the doors of accredited clinics for the voluntary interruption of pregnancy (IVE) at the time of exercising their right to abortion, since approval. This report was sent to the Ministry of Equality and it has been considered as one of the main sources of information in order to review and improve the abortion law submitted for parliamentary approval.

P.46

Strategies against the backlash on sexual and reproductive rights

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Across the world have seen an exponential increase in efforts to restrict the sexual and reproductive rights of women and LGBTQI+ people. Representatives of anti-gender, authoritarian, and fundamentalist movements have become influential actors which have enter in most of the parliaments of the world and even are rule in many states. Unfortunately, we've also seen this concerning turn in the politics and narratives of many members in United Nation. Many gains on sexual and reproductive rights of women and LGTBIQ+ population are under threat of being rolled back due to the effective strategies utilized by the above-mentioned actors.The prohibition of the right to abortion in many countries of the world. The heartbeat Laws approved in different territories of the United States. In light of these developments, it is extremely important that health professionals know who these anti-gender groups, anti-rights and authoritarian states are, what their narratives are, their hate speech as well as their strategies.The communication aims to share the research results of: "Fundamentalist offensive to Democracy. Sexual and reproductive rights defenders confronting anti-gender groups and policies" (Barcelona, Spain 2021)
Methods - Fieldwork to follow up and monitor anti-gender and anti-rights groups at the international and local levels in different feminist platforms. Meetings with the Representatives of the Permanent Missions to the United Nations of the Group of Friends for Gender Equality Bibliographic review.
Results and conclusion - We are facing a transnational phenomenon that is designed in the global space and then implemented at the local level. The global sexual and reproductive rights international offensive is part of a strategy for generate democratizing processes and attack the rule of law. Health professionals must know and be aware of the threat anti-gender and anti-rights movements and authoritarian States pose to sexual and reproductive rights and Health Right.

P.47

Reproductive coercion and abuse: Key issues for reproductive healthcare providers

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Background - Reproductive coercion and abuse (RCA) has been recognised as a specific form of interpersonal violence (IPV) which attempts to promote, prevent or control pregnancy through interference, coercion, threats and violence. Data from elsewhere suggests that pressure or coercion to become and continue a pregnancy is more common than forced abortion. Yet despite this, when RCA recently became a political issue in the UK in relation to abortion care, within the debate over the future of telemedical early medical abortion services (TEMA), much of the focus was on claims that TEMA reduced safeguarding, rather than reporting the increased opportunities it gave to end a forced pregnancy.
Objectives - Although general routine screening for IPV, such as domestic abuse or child sexual exploitation is common across reproductive healthcare settings, there has been less attention to RCA in the UK than in some other countries. This project seeks to address this by developing specific RCA policy guidance.
Methods - This paper will draw on preliminary data from a qualitative project exploring understandings and responses to RCA, focusing on a narrative review of existing literature and thematic analysis of policy debates.
Results - Key issues surrounding the identification and response to RCA that need to be considered

by reproductive healthcare settings include specific RCA screening and safety planning. Yet all approaches need to fully recognise that research on coercive control has revealed the process of recognising or leaving an abusive relationship is often long, complex, and there are many barriers. In addition, the public debate on RCA around TEMA in the UK reaffirmed abortion exceptionalism, which stems from and further increases its stigmatization.
Conclusion - While it is important to ensure that healthcare settings are seen as places where disclosure can take place, disclosure will not occur until victims are ready to do so.

P.48

Perceptions of stigma among women receiving abortion care in Britain

Dr Rachel Scott, LSHTM, London, United Kingdom; Maria Lewandowska, LSHTM, London, United Kingdom; Dr Patrica Lohr, British Pregnancy Advisory Service, London, United Kingdom; Rebecca Meiksin, LSHTM, London, United Kingdom; Jennifer Reiter, Lambeth Council, London, United Kingdom; Dr Rebecca French, LSHTM, London, United Kingdom; Dr Melissa Palmer, LSHTM, London, United Kingdom; Professor Kaye Wellings, LSHTM, London, United Kingdom

Background - Abortion is often framed as controversial and stigmatised in media, public and academic discourse. Abortion stigma has implications for policies that manage access to abortion services and how abortion is experienced.
Methods - Semi-structured interviews were conducted with 43 people with recent experience of abortion in Britain, recruited from clinics. Interviews took place by phone/video-call 2-12 weeks after abortion. The interview guide allowed spontaneous mention of perceived stigma, implicitly or explicitly, at any stage of the care pathway from consultation to aftercare. Inductive-deductive thematic analysis was conducted using the Framework Method.
Results - Stigmatising or judgmental attitudes were anticipated by many participants. Expectations of stigma extended to the clinic environment and surroundings and influenced their evaluation of different facilities. Telemedical abortion services were valued by many for their anonymity, which removed the risk of encountering acquaintances at or near a clinic or of experiencing judgmental attitudes. Reports of enacted stigma on the part of healthcare staff were rare. Many participants described feelings of relief and gratitude when their fears of disapproval or deprecation proved unfounded, and instead they received high-quality, non-judgemental abortion care. Nevertheless, implicit in their accounts was internalised stigma, expressed through the language used in speaking of their abortion and how they came to need it. Themes of guilt, responsibility and shame featured in accounts of both those certain of their decision and those who expressed ambivalence.
Discussion - Despite having little or no perception of their abortion eliciting a stigmatising response from healthcare providers, participants in our study revealed feelings of having themselves been tainted and devalued by the experience. Whether enacted or internalised, the evidence is that abortion stigma has the potential to impair well-being of women. Our findings can be seen as reinforcing the argument for integrating abortion into health care generally, thus normalising the experience.

P.49

#IamJustyna – the cautionary tale about the criminalization of an activist working on self-managed abortion in Poland.

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Justyna Wydrzyńska has worked as an abortion doula for 16 years, founded the hotline and forum Women on the Net, as well as co-founded the Abortion Dream Team. Abortion Dream Team is part of Abortion Without Borders, a European feminist networkt hat provides information, funding and practical support to people in Poland who need an abortion abroad, or access to reliable online sources to obtain abortion medicines. Justyna is facing 3 years in prison for giving a woman in a domestic violence situation a set of abortion pills. This is a story about female solidarity and activism, in the context of a dreadful failure of the state to provide abortion services, state-institutionalized violence against women, oppression of activists and lack of a fair trial. The prosecution was joined by a conservative think tank representing the interest of the fetus. We will present the pathways to gathering strong support from human rights organizations such as Amnesty International, FrontLine Defenders, members of the European Parliament, FIGO and multiple others who categorize Justyna's action as human rights defense work, our tailored communication campaign, and reflect on the actors who remained silent.The objective of the session is to share strategies of defense for community health workers who provide self-managed abortion, as well as provoke reflection and action from our movement in relation to utter incompatibility of local legal regimes on medical abortion provision with the recommendations based on public health evidence and human rights standards. The WHO clearly states that competent community health workers, like Justyna, are recommended providers of medical abortion till at least 12 weeks of pregnancy. This story happened in Poland, but is a cautionary tale for all of us, as abortion pills remain overregulated and medicalized, and competent providers like Justyna risk criminalization in most geographies.

P.50

Outcome of Abortions for Lethal Congenital Fetal Abnormalities in Nigeria following Transition from Restrictive to less Restrictive Regulations

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Background - At least 212,000 women record complications of unsafe abortion annually in Nigeria, due to low contraceptive prevalence rate and the restrictive abortion laws, which only legally permit abortion only to save maternal life, until 2018 when the Ministry of Health guideline on termination of pregnancy expanded the scope for legal abortions. Hitherto, Clinicians were uncertain of how best to manage women with lethal congenital anomalies.
Objectives - To present the indications, parental disposition to abortion, and clinical outcomes of patients with prenatally diagnosed lethal fetal congenital anomalies at the Obafemi Awolowo University Teaching Hospitals Complex (OAUTHC), Nigeria.

Methods - Pregnant women at high-risk for congenital anomalies had fetal anomaly scan between 19weeks – 36weeks gestation from October 2018 to March 2022 at the Fetal Medicine Unit of OAUTHC using the ISUOG 20+2 Planes approach. Identified anomalies were classified into lethal and non-lethal anomalies by a Fetal Medicine Multidisciplinary Team, and the expectant parents were counselled appropriately, including the option of termination of pregnancy for those with lethal anomalies.
Results - There were 372 fetal anomaly scans performed over the period, with the leading indications being maternal medical conditions (88;23.7%), previous congenital anomalies (70;18.8%), previous unexplained stillbirths (62;16.6%), polyhydramnios (56;15.1%) and maternal age>40years (48;12.9%). Thirty-three fetuses (8.9%) with congenital anomalies were identified. Fifteen fetuses had lethal congenital anomalies, including Anencephaly(5), Complex cardiac anomalies(3), Fetal cyclopia(2), Cebocephaly(2), Thanatophoric dysplasia(1), and other multi-systemic anomalies(2). All the parents consented to medication abortion and the diagnoses were confirmed at perinatal autopsy. One patient experienced post-expulsion haemorrhage that warranted transfusion with two units of blood.
Conclusion - Medication abortion is safe and Nigerian women are receptive to termination of pregnancy for lethal congenital anomalies. Easing the restrictive abortion laws in 2018 facilitated institutionalized access to this service, with minimal complications.

P.51

Legal, but still limited

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Background - Although abortion is legal in Georgia on women's request up to the 12th week, women still face a big disparity between law and reality due to biased interpretation and inconsistencies between law and by-laws. Compulsory dissuasive counselling, compulsory waiting period, and unregulated conscientious objection are key criteria hampering the attainment of the highest standard of health.
Objective - To reveal the disparities between law and its implementation which hampers the realization of women's right to safe abortion.
Methodology - The abstract relies on desk review (analysis of legislation, policies, protocols, secondary data analysis) and input from the SARA study of Association HERAXXI (2021).
Results - The wording of the patient's guide contains stigma and contradicts the Ministerial Decree "Pre-abortion Counselling/Interview Rules" (2014) setting grounds for biased counselling.
The COVID-19 crisis and ensuing restrictions complicated access to essential SRH information, services and goods for women/girls. The study reveals incomplete statistics: clinics do not register compulsory waiting period during pandemics. as the national Regulatory Agency recommended providing the abortion service immediately on women's request.
Since the provision of mandatory counselling and the 5-days waiting period requirement (2014), instead of returning to the medical facility, women turned to unsafe methods for termination of the pregnancy.
Conclusion - The study outlines artificially stirred and fed stigma in all layers of legislation, regulation and procedure: Management of medical facilities tend to not position themselves as "abortion providers" leading to the decreased number of abortion clinics; biased counselling, conscientious objection and refusals of care by service providers based on personal belief fed by patient guide; Patients face artificial barriers coming from Mandatory waiting time, the informational vacuum, accessibility and affordability barriers setting the women in the same position, where safe abortion is restricted by weak healthcare system itself.

P.52

Conscientious Objection in the Field of Reproductive Health in Slovenia

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Background -Conscientious objection is, according to the 46th Article of the Constitution of the Republic of Slovenia, a universal human right. The 55th Article provides freedom of choice regarding childbearing; in practice, these issues are dealt with by the field of gynecology and obstetrics. Due to ethical dilemmas arising from this, this medical field is one where conscientious objection is common.
Objectives - To achieve an overview of the extent to which women in Slovenia are capable of fulfilling their constitutional freedom, we collected information regarding conscientious objections by health workers dealing with reproductive health. Additionally, we collected data on conscientious objection regarding prescribing contraception, which in Slovenia is the domain of primary care gynecologists. Emergency contraception is freely available in pharmacies. Due to the Health Services Act, pharmacists have the right of conscientious objection to issuing contraception. Therefore, we sought to find out how many conscientious objections of this type were there.
Methods - Requesting data from the Medical Chamber of Slovenia, Nurses and Midwives Association of Slovenia, and the Slovene Chamber of Pharmacy.
Results - There are currently 8789 active medical doctors in Slovenia, of which 187 (2,1%) are conscientious objectors. Among 392 specialists and residents of gynecology and obstetrics, 5 (1,3%) invoked conscientious objections concerning reproductive health. There are currently 443 active specialists and residents of anaesthesiology; 7 (1,6%) are conscientious objectors regarding reproductive health. There are no data on conscientious objectors in the registry of nurses and midwives, or pharmacists.
Conclusions - Due to the low percentage of health workers with conscientious objections regarding reproductive health of women we conclude that in Slovenia conscientious objections do not play an important role in preventing women from carrying out their constitutional rights regarding childbirth. We conclude that in Slovenia the accessibility of abortion, contraception and emergency contraception is at a high level.

Medical Abortion

P.53

Choice within abortion care pathways: A critical appraisal of the medical abortion revolution in England and Wales

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Medical abortion is commonly celebrated for revolutionising abortion care across different contexts, for example in England and Wales, through the recent development and permanent approval of telemedicine abortion. As in many countries, medical abortion has largely replaced surgical methods in the UK. However, research has not assessed whether the factors driving this shift towards medical abortion reflect health system barriers or patient preferences. Using mixed methods, this research

aimed to critically examine the structural factors behind the growing use of MA in England and Wales, drawing on a multilevel analysis of national abortion statistics and interviews with key informants involved in the provision, management and commissioning of abortion services. Findings suggest that health system constraints on patient choice have influenced the shift towards MA. These include a lack of surgical skills in the workforce, infrastructure requirements, service structure, organisational policy and leadership, cost, reliance on the independent sector, and commissioning practices involving under-funding and competition. Patient choice of surgical abortion before 10 weeks in the independent sector and after 10 weeks in the public sector is limited unless patients can inform and advocate for themselves. While the removal of policy restrictions on medical abortion (e.g. allowing home-use) has expanded patient choice, similar policy progress has not been seen for surgical methods. Commissioners and providers must work together to ensure method choice can be reintroduced into abortion services. This study also calls for more nuanced discussion of the potential benefits and impacts of medical abortion.

P. 54

Improving Medical Abortion through mHealth in Malawi

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Increased access to home-based medical abortion may offer women a convenient, safe and effective abortion method, reduce burdens on healthcare systems and support social distancing during the COVID-19 pandemic. Home-based medical abortion is defined as any abortion where mifepristone and misoprostol medications are taken at home by women. Outcomes include total time spent at a clinic appointment to receive EMA, self-reported preparedness for EMA, level of satisfaction with consultation and effective contraception uptake compared with when women attend for a face-to-face consultation.
Methods - There are no published randomised controlled trials (RCTs) on the use of telemedicine for EMA. Our proposed research was determined that hotline and phone was one of the most approach in delivering information for MA to women. Methods and analysis. This assessment conducted as an RCT. The recruitment target was 1320 participants. Successful abortion was the main outcome of interest. Risk ratios (RRs) and their 95% CIs were calculated. Estimates were calculated using a random-effects model. We used the Grading of Recommendations Assessment, Development and Evaluation approach to assess risk of bias by outcome and to evaluate the overall quality of the evidence.
Results - We identified 6277 potentially eligible published studies. Nineteen studies (3 RCTs and 16 NRSs) were included and women seeking abortion up to 9weeks gestation. Neither the RCTs nor the NRS found any difference between home-based and clinic-based administration of medical abortion in having a successful abortion. The certainty of the evidence for the three RCTs was downgraded from high to moderate by one level for high risk of bias.
Conclusion - Home-based medical abortion is effective, safe and acceptable to women. This evidence should be used to expand women’s abortion options and ensure access to abortion for women during COVID-19 and beyond.

P.55

The change in the induced abortion practice at UMC Ljubljana during the Covid-19 pandemic

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Background - During the Covid-19 pandemic the accessibility of healthcare services not associated with the coronavirus decreased, bringing about the need to adapt abortion practices.
Objectives - To assess the strategies for abortion during the Covid-19 pandemic at University Medical Centre Ljubljana (UMCL) with comparison of induced abortion provision before and during the pandemic and analysing the ratio between medical and surgical abortions from year 2018 to 2021.
Method - The collection of the data on abortion practice at the hospital and the abortion statistics from the information system of the Division of Ob/Gyn at UMCL.
Results - Our data show that regarding medical abortion in the first 9th weeks of pregnancy before the pandemic, the first part of the procedure had patients take mifepristone at the clinic (or at home), and the second part had them take misoprostol two days later at the hospital. During the pandemic the first and the second part of the procedure were carried out at home until the 9th week of pregnancy; after the 9th week of pregnancy the second part was carried out at the hospital. Among our 2557 patients in 2020−2021, only three tested positive for a SARS-CoV-2 infection; in those, the procedure was either delayed or performed in isolation. The ratio between medical and surgical abortions in the first trimester increased in the latest years from 1.78 in 2018 to 4.82 in 2021.
Conclusions - The main change in the practice of induced abortion during the pandemic, as opposed to before, was that the majority of women carried out the procedure at home. This reduced the number of hospitalised patients and consequently the chance of SARS-CoV-2 transmission, while simultaneously enabling women to carry out the procedure in a more comforting environment. Additionally, the ratio between medical and surgical abortions further increased during the pandemic.

P.56

The experience of medical abortion by women in The Netherlands

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In the Netherlands, about a quarter of the 30.000 annually TOP are induced medically (MTOP). International studies show that women are overall satisfied with their choice for MTOP (Harvey, Beckman, & Satre, 2001; Jones & Henshaw, 2002; McKay & Rutherford, 2013). Though these results are not easy to translate to other countries due to large context differences. In the Netherlands, MTOP is provided in a hospital or in 15 abortion clinics, who meet the requirements specified by the Termination of Pregnancy Act of 1984. This method can be chosen up to nine weeks of pregnancy. Women have the choice between a medical and surgical abortion and they receive counselling before and after treatment. A retrospective survey study examined the expectations, experiences and support needs of women undergoing a MTOP in the period of September 2020 and December 2021 in the Netherlands. The reason for the study was the mostly negative experiences with MTOP shared online and with counsellors. Recruitment went through all abortion clinics and 2 hospitals in

the Netherlands. A total of 138 women participated in the study. Participants were 17-46 years old (M= 30; SD=7,1), had an average gestational age of 5(+1) weeks and 66% were highly educated (4% lower education level; 30% medium education level). Results will be presented on how women in the Netherlands experience MTOP and which physical, emotional and environmental factors shape the perception. Knowledge gained from this research will be used to better inform and counsel unintentionally pregnant women.

P.57

Self-Managed Abortion: Context and Safety

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Restrictions on in-person care during the Covid-19 pandemic amplified the importance of access to alternative models of abortion provision, including self-management of medication abortion using mifepristone and/or misoprostol. Global Doctors for Choice (GDC), an international network of physicians who advocate for reproductive health care, works directly with physician groups in Brazil, Colombia, Ireland, Ghana, Kenya, Malta, Mexico, and South Africa. GDC has found that physicians working in different contexts define "self-management" of medication abortion in very different ways. For some, self-management implies the clandestine use of self-sourced pills. For others, it encompasses new models of direct-to-patient telemedicine services. In 2021, GDC assembled a briefing paper on self-managed medication abortion to examine the multiple extant models of self-managed medication abortion. GDC found that clinical concerns with self-managed medication abortion vary according to legal and infrastructural context. GDC therefore proposes a nuanced framework for self-managed medication abortion that considers how context influences the risks of self-management. The framework highlights clinical concerns and advocacy opportunities for each of the components of self-management: drug procurement, eligibility assessment, ingestion, support and management of complications, and follow up. This presentation aims to provide healthcare professionals with an empirical foundation from which to advocate for systemic improvements to the safety and accessibility of self-managed medication abortion within their own contexts.

P.58

Self-care tools for abortion care in humanitarian settings: the role of community engagement in developing medication abortion digital innovations

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Background - The COVID-19 pandemic has catalyzed important interest and investments in self-care and digital health for sexual and reproductive health (SRH), including abortion care. However, for these initiatives to be successful they need to be rooted in participatory design methodologies and reproductive autonomy principles that acknowledge historical practices of community care. Aya Contigo is a digital tool that provides virtual accompaniment on SRH topics including safe medication abortion. It aims at centering self-management to promote the reproductive autonomy of people, including adolescents and youth, who need information, accompaniment, and referrals to SRH services within the Venezuelan complex humanitarian emergency and abortion criminalization context.
Objective(s) - We aim to discuss opportunities and challenges of digital healthcare tools for abortion care by using the development and implementation of Aya Contigo in Venezuela as a case study.
Methods - During 2020 and 2021 we engaged in a collaboratory research and design process that involved a contextual analysis of the Venezuelan humanitarian emergency that included desk

reviews, a survey, and interviews with local SRH organizations and providers, and feminists' grassroots abortion hotlines and collectives.
Results - Insights from this contextual analysis helped us conclude that digital health and self-management are indeed important resources to access care in contexts of humanitarian emergency or in countries where SRH services exist in the context of abortion criminalization.
Conclusions - Engaging with existing communities of care in Venezuela became a key element of Aya Contigo's development and current implementation. Communities of care and abortion accompaniment on the ground not only provide a platform for promoting digital care tools, they can (and should) be included in the design and implementation of safe referral networks for abortion seekers, and in the content development for this kind of digital innovations to be relevant and centered in the needs of users.

P.59

Supporting abortion self-care via digital health interventions at scale: an analysis of IPPF programme data

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Covid-19 restricted access to clinic-based abortion care, so IPPF Member Associations (MAs) in Cambodia, Cameroon and Ghana developed alternative digital pathways for reaching communities with information and support to safely self-manage early medical abortion. In 2021, IPPF launched a project to support MAs with increasing access to person-centred self-managed medical abortion and comprehensive sexuality education for young people. We tracked support services for ASC facilitated by locally designed digital health interventions (DHIs).
Objective - We present the DHI channels developed for ASC services, the types of services provided and experiences with service delivery in three IPPF MAs.
Method - We developed a results framework in collaboration with MAs to track progress against our theory of change. We aggregated data from quarterly reports and produced descriptive statistics of data collected from the project inception in April to December 2021. Project data was complemented by consultations with MA project teams and client feedback.
Results - Through consultation with target audiences and a human-centred design-led process, MAs selected key channels to engage with people seeking ASC support including hotlines, Facebook pages and live chats, telegram, Instagram, and WhatsApp. MAs provided 15,800 ASC support services through a combination of DHIs and in-person support from volunteers, clinic and pharmacy staff. These services included information on self-management (81%), counselling and emotional support (11%), abortion medication (5%) and referrals (2%). Most clients were encouraged to visit clinics, pharmacies or volunteer networks for access to abortion medication. Client feedback points to the need for both digital and in-person support options throughout the ASC pathway.
Conclusion - IPPF MAs use of DHIs suited to the needs and preferences of young people facilitated access to ASC support and information services at scale. Client feedback shows that a combination of in-person touch points and digital support may be needed when scaling up ASC services.

P.60

Intrauterine device placement within 48 hours after early medical abortion – a randomized controlled trial

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Background - Intrauterine devices (IUDs) reduce subsequent abortions. IUDs are routinely placed 2-4 weeks after a medical abortion and patients often miss the placement visit.
Objectives - To study IUD placement immediately after early medical abortion (intervention) vs. placement at a later follow-up visit (control). Primary outcome was difference in IUD use at 6 months after the abortion. Secondary outcomes included placement visit attendance, placement failure, expulsion, ease of and pain at placement and preferred time of placement.
Method - An open-label, randomized study at five Swedish clinics. Eligibility criteria were ≥18 years, requesting medical abortion with ≤63 days' gestation and opting for IUD. After signing informed consent, participants were randomized to have an IUD placed either within 48 hours or after 2-4 weeks from completed abortion.
Results - We did not show superiority in IUD use at 6 months after the abortion in the intervention group (91/111, 82%) compared to the control group (87/112, 77.7%, p=0.51). Placement visit attendance was similar between groups and placement rarely failed. IUD expulsion was seen among 10/109 (9.2%) in the intervention group and 4/111 (3.6%, p=0.10) among controls. Providers rated the ease of placement similar between groups. However, patients reported lower VAS pain scores at IUD placement in the intervention group (mean pain score 32.3, SD 29) compared to the control group (mean pain score 43.4, SD 27.9, p=0.002). A significantly higher proportion of patients preferred their allocated time of placement in the intervention group (83/111, 74.8%), compared to 70/114 (61.4%), in the control group (p=0.03).
Conclusions - IUD placement within 48 hours compared to 2-4 weeks after completed medical abortion did not lead to higher rates of IUD use at 6 months after abortion. However, placement within 48 hours resulted in lower pain scores and patients preferred early placement.

P.61

Medication abortion by mail using a low-sensitivity pregnancy test to confirm completion

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When the REMS criteria was lifted in response to the COVID emergency in 2020, FPA Women's Health began seeing patients self-referred for concerns regarding incomplete medication abortion by mail from outside organizations. Because we have 25 brick and mortar locations as the largest privately-owned family planning organization in California, patients utilized us as a resource for evaluation of complications following medication abortion by mail such as heavy bleeding, pain, or failure requiring surgical management. FPA Women's Health has utilized a low-sensitivity urine pregnancy test (CLIA Waived Ameritek; positive at ~2000 mIU) for follow up of surgical abortion for approximately 10 years. In the 3rd quarter of 2019, we conducted an internal study looking at positivity rates of the low-sensitivity test in medication abortion patients and found that at 1 week 37% of 200 patients had positive results despite completion confirmed via ultrasound. We repeated the study in the 4th quarter at 2 weeks after medication abortion administration and found that

90.6% of patients had a negative low sensitivity test. In July of 2021 we developed a Medication abortion by mail protocol utilizing low sensitivity pregnancy testing. We instructed patients to take a low sensitivity test at home. If the result was positive, patients were instructed to proceed with medication abortion. If the result was negative, they were instructed to come into the clinic for an ultrasound. For those proceeding with medication abortion, we scheduled two follow-up visits. The first was at one week to confirm clinical suspicion of completed medication abortion with a symptom checklist. The second was scheduled at 2 weeks to confirm negative low sensitivity pregnancy test. From July 2021 to present we have administered 329 medication abortions by mail. Of those, 85% followed up via Telehealth. 13 patients required a surgical aspiration (4%) consistent with national standards.

P.62

Detection of ectopic pregnancy and serum beta hCG levels in women undergoing very early medical abortion: a retrospective cohort study

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Objective - To evaluate the outcome of the very early medical abortion (VEMA) protocol and whether it could increase early diagnosis and treatment of an asymptomatic ectopic pregnancy (EP). To investigate serum b-hCG levels correlated to ultrasound findings, and decline in b-hCG after successful VEMA. Study design - A retrospective case-note review. The population consisted of all women undergoinga VEMA during 2004–14 in Austria and 2012–13 in Sweden. Two cohorts identified based on sonography findings; 106 women with an empty uterine cavity were classified as a pregnancy of unknown location (PUL) and 576 women with an intrauterine sac-like structure without a yolk sac or foetal structure were classified as probable intrauterine pregnancy (probable IUP).
Results - Overall, 660 women (97.6%) had a successful VEMA, 94/101 women (93.1%) in the PUL group and 566/575 women (98.4%) in the probable IUP group ($p<0.001$). We identified six asymptomatic EP (0.88%). A gestational sac (< 10mm) was detected at a median/range b-hCG level 2728 (1600–4497) IU/l. The mean decline in b-hCG was 93%, (95% CI 91.7–94.2) 5–10 days after successful abortion.
Conclusions - VEMA may be of particular clinical benefit for women. Apart from offering a possibility to start an abortion without delay as soon as the woman has sought abortion care, it may also offer an opportunity to detect and treat EP at an early gestational age. However, the rate of EP was very low. Moreover, a single serum β-hCG cannot predict nor exclude EP and follow-up at approximately seven days is important. This study confirms previous observations that a decline in b-hCG level by >80% 5–7 days after Mifepristone administration in VEMA can be considered as a successful abortion.

P.63

Medication abortion in I. Vasaraudze's Private Clinic - numbers, experience, conclusions

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Background - In 2020, a total of 5,167 abortions were performed in Latvia, and this number has halved in the last 10 years. In I.Vasaraudze's Private Clinic it was 52 women, which is 1% of all legal abortions performed in the country. Latvia is one of the European Union countries with a very high number of unintended pregnancies and abortions.
Objective - To analyze the profile of patients who have undergone medication abortion in I.Vasaraudze's Private Clinic: age, number of pregnancies, contraception use and complications of the procedure.
Method - analysis of medical history of 315 women who underwent medication abortion.
Results - In the period from 2015-2021 315 women aged 15-46 performed medication abortions at the clinic. It is most often performed by women in the age group of 26-30 years (29%), in the age group 31-35 years (28%) and in the age group 21-25 years (18%). 35% of patients had not given birth at the time of the medication abortion: 31% had their first pregnancy terminated and 4% had a previous abortion history. 32% of women had used contraception before medication abortion: 15% used condoms; 7% practiced coitus interruptus; 1% local contraception; 1% emergency contraception. However, their method of contraception was not effective. After the medication abortion, additional medication was used in 17% of cases to remove the remaining pregnancy tissue. Surgical intervention was necessary in 2% of cases.
Conclusions- Women of active reproductive age (26-35) choose to terminate their pregnancy with medication. Every third woman terminates her first pregnancy. Women who undergo medication abortion did not use safe contraception, although it is easily available. The experience of our clinic shows that medication abortion is a safe method of abortion with a low side effect profile, but it is necessary to develop standards for post-abortion care to exclude subjective data interpretation.

P.64

ACCEPTABILITY & REASONS OF MEDICAL/SURGICAL ABORTIONS IN PAKISTAN: A COMPARATIVE ANALYSIS OF GCACI SDPS-R-FPAP

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Background - People from different sociocultural backgrounds perceive abortion differently. In many countries, abortion is secret, stigmatized, and riddled with personal moral conflicts. Pakistan's abortion statistics are scant and scattered. Even though there are moral questions, research shows that women from many different backgrounds seek abortions, despite the law, religious sanctions, or personal risks.
Objective - To investigate the acceptability and reasons for choosing MA or MVA among women seeking induced abortions in GCACI clinics in Pakistan.
Methods - A statistically calculated sample of (n=377) women with a pregnancy of not more than of 80 days were interviewed between Jan-December 21 who opted MA/MVA at 22 clinics in Pakistan.
Results - The majority of the women seeking abortions were having an average knowledge score of (M=4, SD=0.32) on a scale of 1-10 about abortion procedures. Women with a good knowledge about both methods were more likely to opt MA than women having less knowledge (X2=44.4, df=2, $p<0.05$). 68% of the total women with mean age of 33 years chose MA for termination of their pregnancy. There was a perfect positive correlation (r=97.3) between number of children and choosing MA. Moreover, education, age, background (urban, rural) and family type were significantly

determining the selection of abortion methods significantly. The overall preference of selecting MA was perceived safe, Confidential and natural, self-administered at home, less dependent and less painful. Whereas it was also found that provider's limited knowledge and counseling they received about the procedures were significantly impacting selecting MA/MVA methods. Conclusion: Knowledge and counselling influenced women's abortion choices. All providers must be trained to make MA more accessible by ensuring all women can make an informed choice.

P.65

Women's views of undergoing an abortion with and without pre-treatment ultrasound

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Background - Prior to the COVID-19 pandemic, it was the standard of care in Britain that an ultrasound for gestational age determination was a routine part of a pre-abortion assessment. Since the pandemic, national guidance has advocated for abortion to be provided with a scan only if indicated, such as when the gestation cannot be estimated by the last menstrual period. Widespread implementation of this pathway has secured access to abortion care for large proportions of women during the pandemic. However, little is known about the experiences and opinions of those undergoing abortions about having or omitting an ultrasound during the care pathway. This project aims to examine this question through in-depth interviews with participants who have undergone abortion in the 'scan as indicated' model. Primary objective - To understand the experiences and opinions of women who have undergone telemedical abortion without a pre-procedure ultrasound. Secondary objectives: 1) To compare the experiences of having an abortion without an ultrasound to prior experiences of abortion when an ultrasound was performed as part of the care pathway. 2) To explore women's perspectives on the routine or selective use of ultrasound as a reflection of quality in abortion care. Study Design: Women who had an early medical abortion at British Pregnancy Advisory Service which did not include the use of routine ultrasound and a prior abortion where a scan was undertaken will be invited to take part in qualitative interviews. We will enroll 20-24 participants for an interview by phone, video call, or in-person. We anticipate that interviews will take approximately 60 minutes. Interviews will be recorded for analysis of codes and themes. We will share thematic analysis to include preferences for model of care, experiences of having and omitting an ultrasound, reflections on reasons for preferences, and perceptions of quality of care.

P.66

MISSED ABORTION, THE EXPERIENCE OF AN ITALIAN HOSPITAL ON 3.014 MEDICAL TREATMENTS WITH MIFEPRISTONE (RU486) AND PROSTAGLANDIN

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Since the introduction of mifepristone in 2010 we have started using medical treatment with mifepristone (RU486) and prostaglandins for missed abortion. In 2021, medical procedures for missed abortions were 395 (56.5%) out of 699. Surgical treatments for failure were 18 (4.3%) out of 395 procedures. Overall, since 2010 we have had 3,014 missed abortions treated with mifepristone and prostaglandin, with 146 cases (4.8%) which resulted in non-expulsion. The failure rate was 50%

higher than for medical abortion procedures, which in our case series is 3.2%. Our experience confirms that it is possible to offer medical management for missed abortion, which is a safe, effective and simple method, as an alternative to surgical or waiting methods.

P.67

Client experience of pain and pain management during medical abortion up to 10 weeks' gestation at the British Pregnancy Advisory Service (BPAS) – a cross-sectional evaluation.

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Background - There is currently no consensus on optimum analgesic regimens to manage medical abortion pain beyond the use of NSAIDs, and prescribing practices vary between providers. In March 2021, BPAS changed its clinical guidance on codeine provision during medical abortion up to 10 weeks' gestation from routine prescription to all eligible clients to tailored prescription (wherein codeine is offered as an option following counselling). This evaluation assesses client experiences of pain and pain management during medical abortion following this service change.
Objectives - To evaluate the association between model of codeine counselling and provision on the outcomes of satisfaction with pain management (5-point Likert scale) and maximum abortion pain score (11-point numerical rating scale).
Method - Consenting clients who underwent medical abortion up to 10 weeks' gestation between 7/11/21 and 3/3/22 were contacted by email or text message to complete an online anonymous English-language survey, with questions about medical history, abortion characteristics and experience of pain and pain management.
Results - 11,906 clients consented to be contacted about BPAS research or evaluations; 1,625 clients completed the survey (14% of those contacted). Mean maximum abortion pain score was 6.8. 1,233 clients (76%) were satisfied with their pain management. 801 clients (49%) reported that their clinician offered codeine as an option following discussion (tailored prescription) and 602 (37%) reported being told that codeine would be prescribed automatically (routine prescription). Clients in the tailored prescription group were more likely to report satisfaction with pain management (OR 1.53, 95% CI 1.19-1.96, $p<0.01$) and lower pain scores (OR 1.25, 95% CI 1.04-1.51, $p=0.02$) than those in the routine prescription group.
Conclusions - The findings support a tailored rather than generic approach to prescribing opioids for pain during medical abortion up to 10 weeks' gestation, in which clients are counselled about codeine and offered the choice of a prescription.

P.68

What do young people need to manage their own medical abortions: results from a social media survey & qualitative interviews of young people in Colombia

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Background - Limited data exist about the ways in which young people access information about sexual and reproductive health (SRH), including abortion and contraception.
Methods - We conducted an online survey and individual qualitative interviews to determine how young people in Colombia access information about SRH, and to define their preferences for a digital tool to improve an existing teleabortion service, MIA. We disseminated the survey through social media ads on the website and social media pages of a popular reproductive health non-profit organization (Profamilia). We recruited individuals who had used the Mia service and those who had not from 5 municipalities and conducted semi-structured individual interviews. We conducted descriptive statistical analyses using Stata SE Verstion 16.0. Qualitative analysis was completed through NVivo using thematic analysis. The Profamilia IRB approved the study.
Results - A total of 5736 individuals responded to the survey, of whom 5660 (98.5%) identified as women. The mean age was 23.4 (+/- 3.4). Almost all respondents (98.4%) had access to a smartphone. Most respondents (80.8%) said they would be very likely to use one of those devices to access SRH information. When asked about the first three things respondents would do if they had a concern their SRH, the most popular responses were: searching an Internet browser (66.8%); going to a health clinic (56.8%); and asking friends (34.4%). Key themes highlighted from interviews included the need for more trusted, evidence-based information that was comprehensive and inclusive, Tik Tok and WhatsApp are popular mediums of information gathering and connecting the digital tool with existing feminist collectives was seen as essential.
Conclusions - Young women in Colombia appear comfortable using mobile devices to access SRH information. An app that is comprehensive, inclusive, and private is needed as an improved adaptation of the current teleabortion service, Mia.

Pain and Risk Management

P.69

Prospective analysis of the association between perceived stigma and post-interventional pain during first-trimester abortion

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Background - In Germany 95.8% of abortions are performed within the scope of a consultation arrangement, which grants prosecution-free abortion within the first trimester if patients have undergone a process of mandatory counseling beforehand. There is currently a lack of studies investigating factors which might influence abortion-related pain perception.
Objectives - The focus of this study is the analysis of association between individual perceived stigma and post-interventional pain. Because of the association between stigma and mental comorbidities, additional assessments of anxiety and depression are performed.
Methods - The questionnaires used for this study include the ILAS Scale (Individual Level of Abortion Stigma), GAD-7 (Generalized Anxiety Disorder) and PHQ-9 (Patient Health Questionnaire). To measure pain a NRS (numeric rating scale) from 0 to 10 is applied.
Results - Since the start of our ongoing study on the 22th February 2022 we were able to include 57 patients. 20 patients received a medical abortion, 17 a surgical abortion with local anesthesia, and 20 with general anesthesia. The median patient age is 28.0 years with a median gestational age of 50 days of pregnancy. Based on the current data, the Pearson correlation coefficient between the ILAS score and the NRS score of the surgical abortion with local anesthesia is 0.42 (p=0.096), with general

anesthesia -0.23 (p=0.34) and -0.53 (p=0.227) with medical abortion. The median NRS scores to each method are 3 (IQR 3-5), 2 (IQR 0-4.25) and 7 (IQR 6-8.5).
Conclusions - The quick accrual of 57 patients indicates that our ongoing study is feasible and that the planned recruitment of 500 patients is possible. First results seem to confirm our hypothesis that there is an association between perceived abortion stigma and abortion-related pain perception. Further data are needed to confirm and characterize this preliminary observation.

Second Trimester and More

P.70

Choice of Method in Abortion for Fetal Anomaly (TOPFA) in a District Hospital: a quality improvement initiative

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Objective - We set out to examine whether offering choice of method to women undergoing late 2nd trimester TOPFA is valued and whether it leads to a change in practice.
Design - Since 2017, Homerton Hospital (HUH) abortion service has increased the gestational age limit for surgical abortion (D+E) to 24 weeks. Choice of method was therefore offered to fetal medicine patients up to 24 weeks in keeping with good practice and the subsequently published NICE guidelines (1).
Methods - Women requesting TOPFA are counselled regarding options. After June 2017 this counselling included choice of medical or surgical abortion up to 24 weeks. Pregnancy outcomes were analysed. We present the data relating to all patients having TOPFA between 20 and 24 weeks gestation from June 2017 to August 2021 (n=47).
Results - The trends in decision making over time demonstrate a rapid change in preference. There has been an increase in the proportion of patients choosing surgical abortion, from <20% in 2017, 56% in 2018, 62% in 2019, 89% in 2020 and 100% in the first 8 months of 2021.
Conclusions - Historically at HUH, in keeping with most other fetal medicine units, women having TOPFA >16weeks were only offered medical abortion. Our study demonstrates that our patients place a high value on choice and that the majority now choose surgical abortion up to 24weeks. We believe that these findings have important implications for all FMU departments and for the provision of abortion services more widely. The offer of choice is of critical importance for the wellbeing of women(2).

National Institute for Health and Care Excellence (NICE). NG140.
Kerns J, et al. Women's decision-making regarding choice of second trimester termination method for pregnancy complications. Int J Gynecol Obstet 2012 Mar 1;116(3):244–8.

P.71

Gaps in Later Abortion Care in Europe and the USA

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There are significant gaps in later abortion care in Europe and the United States. In Europe, while most countries offer abortion on request in the first trimester, access to second trimester is far less accessible. In fact, only four countries in Europe have abortion on request after the first trimester. Restrictive laws and regulations make accessing later abortions difficult for some living outside of those countries, and almost impossible for others who face additional obstacles such as insecure immigration status, poverty, and logistics and travel barriers. To address these barriers, Europe's fairly new abortion fund network is trying to plug the gaps. In the US there are long waits at clinics in the few states that can provide later abortion care, and the cost of this care is often prohibitive. People are driving hundreds of miles or flying across the country to access this care, which is often not covered by insurance. The Later Abortion Initiative at Ibis Reproductive Health and Abortion without Borders will present the scope of these problems and some shared solutions.

P.72

Outcomes of mifepristone-misoprostol Prep in 2nd Trimester Abortion: A Hybrid Method

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A Prospective cohort study looking at an induction medication abortion protocol for 359 women presenting for termination of pregnancy 18.0-23.6 weeks LMP was undertaken. We set out to show that medication induction abortion could be safely incorporated in a US outpatient abortion clinic. The primary outcome of the study was procedure efficacy, defined as complete abortion within procedure day. Our secondary outcomes included abortion outcome type (D&E/induction), safety, median time to outcome, and D&E procedure time All patients were given mifepristone 200 mg and digoxin intra-vaginally on Day 1. On Day 2 patients had AROM and misoprostol 600 mcg then misoprostol 400mcg q2hours. If there was no delivery by end of clinic day, D&E was performed. Time of procedure or length of induction were recorded documented. Overall, results indicate that induction 2nd trimester medication abortion can be done in an outpatient clinical setting. Of the total 359 patients, 64% delivered and 36% had a D&E. Patients were more likely to be successfully induced at higher gestation (P> 0.000) and without a history of cesarean (P> 0.001). The mean time for the D&E was 12 min and the mean time for induction was 6.3 hours. Complications were rare.Use of medication abortion later in pregnancy offers an effective way to complete these abortions without osmotic dilator placement or D&E training. Advantages include that it can be provided by family physicians and midwives, either in a clinic or hospital setting, where the induction window could be extended to eliminate need for D&E. This could transform US abortion access in later in pregnancy. Clients could receive care locally, and in US states with D&E bans, medication indiction abortion could be offered. Future research is currently underway to assess patient and staff acceptibilty.

P.73

In their hands: Improving provider competences in Second Trimester Abortion and its impact on high quality service delivery and service uptake in Cameroon and Uganda.

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Background - Surgical abortion beyond 12 weeks of gestation is safe and reliable when performed by a competent health care professional. As part of the Global Comprehensive Abortion Care Initiative (GCACI) in Africa led by IPPF, this project sought to increase access to high quality Second Trimester Abortion (STA)services by improving IPPF Member Association clinical providers' capacities through on-the-job and stand-alone trainings.
Objective - This abstract presents the results of targeted and consistent service provider capacity building STA in Cameroon and Uganda on provider confidence, client service uptake, and subsequent delivery of high-quality abortion services beyond 12 weeks gestation in 2021.
Methods - In Cameroon, providers received a theoretical refresher course on MVA for abortion beyond 12 weeks, followed by practical exercises on dummy cases, while in Uganda, an on-job learning approach was used that enabled providers to learn from each other in a work setting. 2020 and 2021 country data from DHIS2 were analysed to reveal trends in STA service provision numbers over the two years.
Results - Following the training, 100% of providers said they felt sufficiently equipped to perform second trimester abortion service and transfer skills to other providers in MA and partner clinics.
In Cameroon, the refresher trainings for providers on abortion beyond 12 weeks contributed to a 120% increase in clients who received this service between 2020 and 2021. Uganda witnessed a 26% increase in the number of clients provided with STA using surgical methods at the end of the year. In addition, 98% and 93% of all abortion clients in Uganda and Cameroon respectively opted for post abortion contraception at the end of the procedures.
Conclusion - Service provider confidence in delivering abortion services beyond 12 weeks is driven by high quality training which has a direct impact on client service uptake and quality of care.

Statistics

P.74

The prevalence of intimate partner emotional, physical, and sexual violence among women who have an induced abortion in the Riga Eastern Clinical University hospital (preliminary data)

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Background - Intimate partner violence (IPV) against women is a worldwide public health problem. Regardless of the type of violence (emotional, physical, or sexual), it significantly impacts women's sexual and reproductive health.
Objectives - To determine the prevalence of emotional, physical, and sexual intimate partner violence and its impact on women's reproductive health in women seeking termination of pregnancy.
Method - A quantitative, cross-sectional study of women who attend the Gynaecological clinic of the Riga Eastern Clinical University hospital for induced abortion. Eligibility criteria are women aged 18 or older who agree to participate in the study. Participants fill out an anonymous, self-completed questionnaire (in Latvian or Russian), that consists of questions about sociodemographic

characteristics, women's sexual history, and specific acts of physical, sexual, and emotional violence in the last 12 months and in a lifetime perpetrated by an intimate partner or other people. Data is conducted from April till May 2022. The study is approved by the Ethics Committee of Riga Stradiņš University.
Results - These are preliminary data of an ongoing study. Currently, there are 12 women involved in the study. The prevalence of IPV (including physical, emotional, or sexual in the past year or during a lifetime) is 33% (n=4). Two identify a former and two women a current partner as a perpetrator, furthermore current partners are violent in the last 12 months. Three of the participants have physical, three emotional, and none of them sexual violence. Another perpetrator of violence reveals three of 12 women and all of them experience it during their lifetime.
Conclusions - Women who terminate the pregnancy experience high IPV rates, indicating the need for the continuation of the study. During pre-abortion consultations targeted screening of IPV is important. Women should be provided with the information on where to get support in case of IPV.

P.75

Mapping the regional distribution of abortion providers in Germany

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In Germany, abortions are regulated by §§ 218 ff. of the German Penal Code (StGB). Around 95% of all abortions in Germany take place during the first 12 weeks after mandatory counseling and 3 days mandatory waiting time (§ 218a para. 1 StGB). Although these abortions are considered unlawful under Section 218a of the German Penal Code, they remain exempt from punishment. Due to this unlawfulness, abortion care is currently not ensured through regular planning instruments of health care. According to media reports, there is already an undersupply of abortion providers in some regions in Germany. As a result, women have to put up with long distances and long waiting times in these areas. The legal framework in Germany does not allow for adequate data on the regional distribution of abortion providers. The federal states are supposed to ensure a "sufficient" supply of abortion facilities (§ 13 para. 2 SchKG). However, there is a lack of concrete guidelines on what is considered "sufficient". The Federal Statistical Office (StBA) does record the facilities that report abortions for its federal statistics on abortions, but these reporting facilities have to be kept secret due to confidentiality regulations. In addition, these figures are only recorded at the level of the federal states. The state level does not provide sufficient detail to identify regional undersupply. The poster will present maps on the regional distribution of abortion providers in Germany on the grounds of data collected in the ELSA study and small-area data, provided by the Federal Statistical Office exclusively for the ELSA study. Regional differences in the availability of abortion care in Germany are presented. Gaps in the existing data situation will be pointed out.

P.76

The prevalence of intentional abortion in Iran during 1996-2020: An explanation for risk factors

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Background - With consideration of the Iranian government policy and cultural background, Iran has strict laws against intentional abortion. But, in recent years the rate of intentional abortions has grown significantly compared to the population growth rate in this country, and it has one of the high statistics rate of abortion in the world. According to rules, pregnancy without marriage is prohibited and criminal so in many times induced abortion has been done as illegal operation,

without standard conditions that could be harmful for women.
Objectives - The purpose of this study was to find the causes of the significant increase in the rate of illegal abortions in Iran to help to improve women's health.
Method - This retrospective study was done through gathering data from annually abortion statistics information through official sources during 1996-2020. In addition, the demographic data (sex, age, marriage, divorce , education, social welfare parameter) were evaluated through the Statistical center of Iran.
Results - Our data showed there were 15,235,416 of women aged 14 to 44 years in 1996 with 479,263 cases of marriage. During this year the intentional abortion rate was 4.9 per thousand women of the above ages. While in 2020, with 21,323,829 women aged 14 to 44 years, the rate of abortion has been increased to 23.4 per thousand. It was reported that only 1.4% of abortions were legally licensed due to maternal illness or fetal defects. Decreased social welfare, increased the number of women in fertility age, decreased in marriage rate, increased in mental health problems, difficult access to contraceptive services, decreased to sexual health issues were some of the reasons can explain the 5 times increase in intentional abortion.
Conclusions - This study suggests that pay attention to above items and judicial supports can improve women's health and reduce the rate of abortion.

Surgical Abortion

P.77

Provider understanding of patient access to medical and surgical abortion across Australia and the impact of the COVID-19 pandemic

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Objectives - To identify variability in patient access to medical and surgical abortion across Australia based on distance from an urban centre and determine the impact the COVID-19 pandemic had on pre-existing distance related access barriers.
Methods - Cross-sectional survey of primary care providers across Australia. Respondent postcodes were coded into Australian Statistical Geography Standard (ASGS) groups.
Results - There were 636 provider responses from across Australia of which 445 (70%) were based in major cities, 119 (18.7%) in inner regional areas, 52 (8.2%) in outer regional and 20 (3.1%) in remote or very remote locations. With regards surgical abortion, 39 (6.1%) did not know the distance a patient would have to travel but of the remaining respondents the proportion having to travel >100km increased from 1.2% in major cities, to 28.4% in inner regional, 55.8% in outer regional and 88.9% in remote/very remote locations ($p<0.001$). Despite telehealth, access to medical abortion, was still significantly less in regional and remote areas with over 70% of patients having to travel >100km compared to major cities where only 1% had to travel this distance. Covid-19 reduced access in all regions, but most significantly in remote and very remote areas.
Conclusions - Women living in regional and rural and remote Australia have reduced access to both surgical and medical abortion compared to women in major cities. This disparity was worsened during the COVID-19 pandemic.

P.78

Intrauterine adhesions after termination of pregnancy

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Background - Termination of pregnancy (TOP) is one of the most performed interventions in women worldwide: approximately one in three women will have at least one TOP in their reproductive life. Intrauterine adhesions (IUAs) have been reported as a possible complication after TOP, especially after surgical TOP. As women are not evaluated routinely the true prevalence remains undetermined. In a systematic review IUAs were reported in 21.2% evaluated by hysteroscopy following first trimester surgical TOP; adhesions were moderate to severe in 48%.
Objectives - Are the long-term reproductive outcomes in women with identified and treated intrauterine adhesions (IUAs) after TOP comparable to women without IUAs.
Method - We searched Ovid MEDLINE, Ovid EMBASE and CENTRAL for studies evaluating long-term reproductive outcomes in women with IUAs following TOP. Studies in which women were evaluated consecutively, independently of symptoms for the presence of IUAs were included.
Results - After an extensive review of the literature, no studies were found that reported long-term reproductive outcomes in women with identified and treated IUAs following TOP. One study reporting long-term reproductive outcomes in women following a D&C for miscarriage. D&C for miscarriage is considered a different clinical condition, although the surgical intervention is identical. Reproductive outcomes in women with identified and treated IUAs following D&C are impaired compared to women without IUAs; fewer ongoing pregnancies and live births are achieved with a prolonged time to a live birth.
Conclusion - There is a link between surgical TOP and IUAs adhesion formation. As IUAs have an impact on reproductive performance, even after hysteroscopic adhesiolysis, primary prevention is essential. Further research is required to establish the best management in case of TOP. Medical management should be considered a serious alternative for surgical TOP as no IUAs have been reported following medical TOP, although the evidence is limited.

Unsafe or Safe Abortions

P.79

Self-managed Abortion in the USA; A safe and effective response to abortion restrictions

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The right to abortion has been undermined in the USA, and over half of the states are moving to ban or severely restrict abortion services. A network of formal and informal groups is working to share information about abortion pills and how to access them. This approach lies at the intersection of public health, reproductive justice, and feminist autonomy, and is based on years of research and experience that abortion pills are effective, safe, and can be managed by those who need them without a clinician. Information about the rise of self-managed abortion (SMA) will be highlighted. Additionally, the state has an obligation to provide health care and clinicians have a critical role to play in post-abortion care and in supporting, not reporting, patients. Over 1/3 of those arrested in the USA were turned in to the police by a healthcare provider, and this is a violation of medical/professional ethics.

P.80

Expérience de l'Organisation pour de Nouvelles Initiatives en Développement et Santé (ONIDS) dans la communication et la mobilisation d'alliés communautaires pour l'accès à l'avortement sécurisé au Burkina Faso

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Le Burkina Faso à l'instar d'autres pays africains a dégradé et signé le protocole de Maputo en 2006. Le code pénal a aussi été revu (réduction du nombre de médecin de 2 médecins dont 1 du public à 1 médecin pour autoriser l' avortement dans les conditions légales, le rehaussement de l'âge de la grossesse de 10 semaines à 14 semaines d'aménorrhée pour l'accès à l'avortement en cas d'inceste ou de viol). Malgré ces efforts, le taux de mortalité lié aux avortements clandestins reste encore très élevé du fait de la connaissance du statut légal de l'avortement : seulement 1/3 des femmes burkinabè savent que l'avortement est autorisé dans certains cas. L'avortement est donc pratiqué en cachette de façon illégale diffusé ainsi la vie des femmes et des filles en danger.ONIDS dans son rôle de défenseur des droits des femmes a formé en 2020 et 2021, 53 parajuristes au niveau des régions du Centre et du Centre-Est sur le cadre juridique de l'avortement, dans le but de contribuer à la réduction des décès maternels liés à l'avortement. Ces parajuristes sont des relais communautaires issues des communautés qui, simplifient le langage juridique au sein de leurs communautés. Les survivantes de violences sont référées pour une prise en charge juridique, judiciaire, psychologique et médicale. Cette intervention a permis au cours de l'année 2020 et 2021 de toucher 25411 personnes. 9 filles ont fourni une prise en charge holistique dont 7 pour une prise en charge psychologique, 3 pour une prise en charge médicale et 2 pour une assistance juridique. Les sages-femmes points focaux ont quant à elles enregistré 579 demandes de services d'avortement. Nos actions ont permis de faciliter l'accès à l'avortement sécurisé dans un contexte où les autorités publiques font très peu d'efforts pour vulgariser les textes en la matière.

P.81

An Impact Evaluation of Global Comprehensive Abortion Care Initiative (GCACI) Project

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Background - This Impact study assesses the changes brought by the GCACI project in the key domains related to service delivery and system strengthening, particularly, the changes in policy advocacy.
Objective - The objective of this impact evaluation is to understand and document the main results and changes brought by the GCACI project over the span of 14 years (2008-2021).
Methodology - The present evaluation adopted a mix-method design (qualitative and quantitative). The qualitative study comprised of key informant interviews with branch managers and service providers (doctors/nurses), observation of the FPAN's Family Health Clinics (FHC), and focus group discussion (FGD) with three categories of the participants
Result - GCACI has contributed significantly towards FPAN's core abortion programme - both in terms of service expansion and medical/clinical human resources support. The Initiative created good opportunities for FPAN to try out new approaches and interventions to improve access to abortion and contraceptive services. Over a span of 14 years, FPAN has provided safe abortion care to 70,090 women. Of this total, 34,909 women (49%) had obtained surgical abortion (MVA) and 35,181 women (51%) had obtained MA. A total of 2561 woman had undergone treatment of incomplete abortion (TIA) from FPAN. Eighty-four percent of abortion clients had accepted post abortion contraception. A

total of 239,259 clients have received at least one FP service from FPAN, of which 18% of the clients had obtained long acting contraceptives (LARC).
Conclusion - This evaluation has shown that FPAN was successful in obtaining the GCACI funds for five successive phases of project funding (2008–2021). Key contributing factors to FPAN's success in receiving the GCACI funds include: establishment and strengthening of quality SAS, LARC, TIA and VIA services at all FHCs.

P.82

Reality of unsafe abortion in Palestine

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Background - Worldwide, 56 million abortions estimated on average each year in 2010-2014 whereby 26 million legal and 20 million illegal abortions took place every year. Most cases of abortion (55%) were reported in developing countries and particularly in South-central Asia, WHO (2016) report clearly showed that the annual abortion rate is higher in developing regions (37 per 1,000 women) than in developed regions (27 per 1,000 women). Therefore, understanding the underlying factors behind unsafe abortion will be helpful to minimize abortion related complications such as maternal mortality.
Objectives - The study aimed at identifying the current levels of unsafe abortion, access to abortion related services and unmet needs for safe abortion services in Palestine.
Methods - This study adopted mixed method (quantitative and qualitative) approach. The cross-sectional design was adopted to assess women's knowledge, attitudes and practice toward abortion and their perception of abortion-related services. The Qualitative data was collected using individual interviews and focus group discussions. Quantitative and qualitative data were collected simultaneously.
Results - Numbers showed that almost 57% of the sample had known a person who had an abortion in the year 2018. 37% of the sample reported having previous abortion history. The analysis revealed many causes of abortion including congenital anomalies, female fetus, unplanned and unintended pregnancy, economic problems, having too many children, conflict with the husband, mistakes by obstetricians, threat to women's life and lacking knowledge of what threatens pregnancy.
Conclusion - The findings help in identifying characteristics of women who undergo abortion, causes of abortion, public perceptions of abortion and misconceptions that both women and health care providers held about abortion. It illustrates the significant role that policy makers can play in adopting and designing appropriate strategies to protect women's health and well-being.

P.83

Delays in the request for pregnancy termination: comparison of clients in the first and second trimesters in Madhya Pradesh, India

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Globally, it is observed that about 10% of abortions (of the induced abortions) among women used to be terminated during second trimester in most of the more developed and developed countries and the corresponding figure is noted as modestly at higher side in India and South Africa (25% – 30 %). Worldwide, it is evidenced that second-trimester abortions would result in associated with higher risks of morbidity and mortality, as compared with first-trimester abortions, in settings where unsafe abortions are widespread. it is worth understanding the background characteristics of women who seek second trimester abortion services or in other way around the risk factors (characteristics) that

lead to second-trimester abortions. In the present study, 109 women with Second-trimester abortion (STA) and 428 women who underwent first trimester abortion (FTA) were included in the research study. Socio-demographic factors, obstetric history and contraceptive history were considered as explanatory variables. Univariate and multivariable binary logistic regressions were used to examine the determinants of the primary outcome variable. Odds ratios were estimated to examine the strength of the associations, and 95% confidence interval (95%CI) was used for significance testing. P value < 0.05 was considered statistically significant. 'Residence', 'income', 'education' and 'ever used contraceptive' variables were found to be significant predictors of second-trimester abortion in multivariable analysis. Women from rural area were 3.83 times (aOR 3.83, 95% CI 1.69-8.69) more likely to undergo second-trimester abortion as compared to women from urban areas. Monthly family income less than INR 75,000. Women with no formal education were 3.66 times (aOR 3.66, 95% CI 1.60-8.35) more likely to undergo second-trimester abortion as compared to women with above higher secondary education. Those who had never used contraceptives were 2.71 times (aOR 2.71, 95% CI 1.39-5.26) more likely to undergo second-trimester abortion as compared to those who had used contraceptives.