



Royal College of
Obstetricians &
Gynaecologists

Coronavirus (COVID-19) infection and abortion care

Information for healthcare professionals

Version 3: Published Wednesday 3 June 2020



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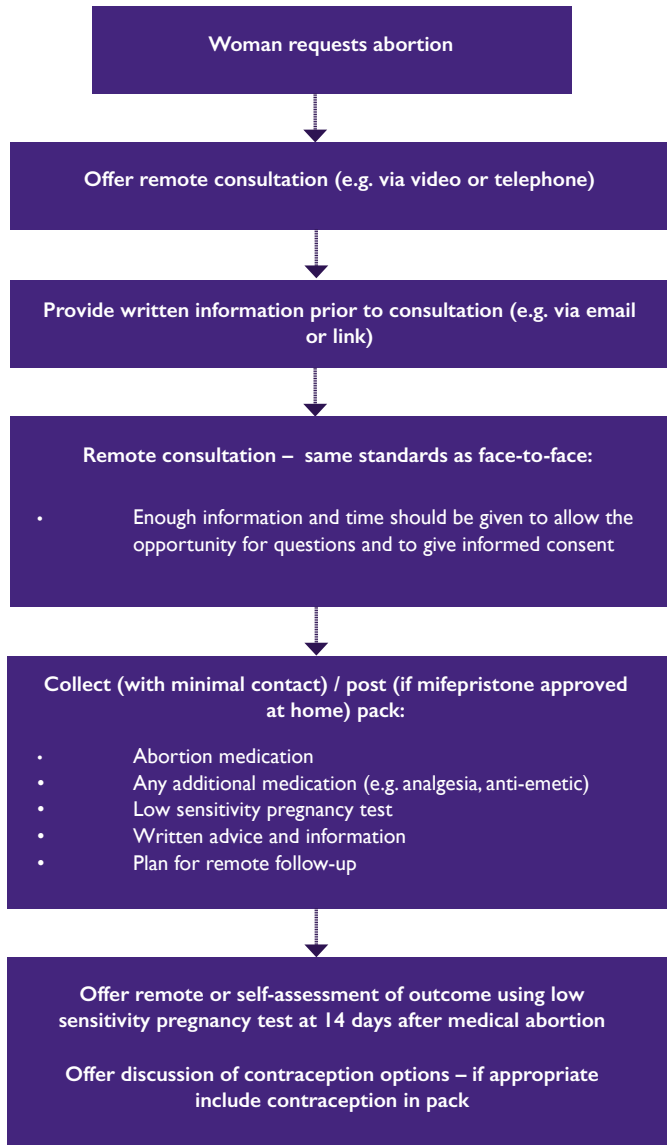
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Summary of updates

Version	Date	Summary of changes
3	3.6.20	Flowchart: Summary of early medical abortion care management during COVID-19 pandemic: wording included re offering remote or self-assessment of outcome using low sensitivity pregnancy test at 14 days after medical abortion
3	3.6.20	1.3: Added sentence regarding the developing services in Northern Ireland.
3	3.6.20	1.3: Reordering of text around temporary regulations and Scottish Government issuing new regulations; amendments to years when nations allowed misoprostol at home; and addition of information about remote consultations in Northern Ireland.
3	3.6.20	1.4: Additions to reflect advantages to an unknown number of vulnerable women receiving care within the healthcare system, as opposed to accessing unregulated forms of abortion care.
3	3.6.20	1.4: Data from the first 6 weeks of providing medical abortion through telemedicine has been added.
3	3.6.20	1.4: Further information added on the impact of delays to abortion care to both women and the healthcare system.
3	3.6.20	2: Added bullet point on delivering post-abortion care via telemedicine.
3	3.6.20	2.1: Ultrasound scanning section re-formatted and additional information on gestation assessment and ectopic pregnancy included. New evidence added from American guideline and literature review.
3	3.6.20	2.2: Changes to wording of section on RhD status and anti-D immunoglobulin.
3	3.6.20	2.2: Removed reference to a small study on concentrations of fetal red blood cells in pregnant women before and after uterine evacuation.
3	3.6.20	2.4: Minor changes to analgesia advice following reduced concern over ibuprofen in COVID-19.

Version	Date	Summary of changes
3	3.6.20	2.4: Added more information on counselling and what the effects are of an early medical abortion.
3	3.6.20	3: Added loss or change to sense of smell or taste to symptoms of COVID-19.
3	3.6.20	3: Added information that women requiring an abortion in different settings due to COVID-19 need to be supported by staff trained in providing abortion care.
3	3.6.20	4: Clarified that a more detailed safeguarding assessment applies to vulnerable women and children under the age of 16.
3	3.6.20	4: Added a further bullet point around the need to establish that, where English is not a first language, the woman has understood the process and had the opportunity to ask any questions.
3	3.6.20	4: Added a sentence on how telemedicine widens access to vulnerable women seeking abortion care.
3	3.6.20	5: Modified to reflect changes in allowed gestations in Scotland, and additional advice where home abortion is desired after 10 weeks.
3	3.6.20	5: Consideration added on whether to discuss with women if they wish to be discharged to complete a medical abortion at home in the early second trimester; based on a risk assessment and informed choice.
3	3.6.20	6: Clarified that the number of abortions carried out in the independent sector is in England and Wales, not Scotland.
3	3.6.20	6: Additional bullet point on need for providers to minimise any distress caused by a transfer of care.
3	3.6.20	6: Additional bullet point added on reducing hospital attendance by providing abortion care to women with a complex comorbidity outside of a hospital.
3	3.6.20	6.1: Clarified that women should be supported when being referred to another provider.
3	3.6.20	6.1: Added contact details for 'Informing Choices Northern Ireland'.
3	3.6.20	7 Clarified remote prescribing powers in England, Wales and Scotland for early medical abortion.

Summary of early medical abortion care management during COVID-19 pandemic



Abortion is essential health care

Services should be organised so as to minimise delays in care

Provide ultrasound if:

- Unable to provide LMP of reasonable certainty within thresholds of eligibility or skill of provider
- History or symptoms suggestive of high risk of ectopic pregnancy such as:
 - Unilateral abdominal pain and vaginal bleeding/spotting
 - Intrauterine device in-situ
 - History of tubal damage
 - Prior ectopic pregnancy

No need for routine blood testing

If STI screening indicated or chlamydia test recommended, use remote service (e.g. web-based home testing)

Consent can be given verbally, but discussion must be recorded in notes

Safeguarding assessment should be individualised; clinicians must be confident the woman can speak privately without coercion

Consider other ways to manage available resources and offer woman-centred care:

- Maximise the use of nurses
- For surgical abortion, consider pain relief that does not require theatre facilities or anaesthetic support
- Consider medical abortion in second trimester
- Collaborate with other providers
- Support staff to work from home where appropriate

I. Introduction

Gender

Within this document we use the terms woman and women's health. However, it is important to acknowledge that it is not only people who identify as women for whom it is necessary to access women's health and reproductive services in order to maintain their gynaecological health and reproductive wellbeing. Gynaecological and obstetric services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

I. Introduction

The following advice is provided as a resource for UK healthcare professionals and providers based on a combination of available evidence, good practice and expert advice. The priorities are the provision of safe care to women, including those with suspected/confirmed COVID-19. Please be aware that this is very much an evolving situation and this guidance is a living document that may be updated if or when new information becomes available. We therefore suggest that you visit this page regularly for updates.

This guidance applies to women who are requesting an abortion. During the COVID-19 pandemic access to normal healthcare processes will be disrupted. To ensure safe and effective abortion care, greater use of remote consultations and medical abortion at home may be necessary, especially where women and staff may be self-isolating or acute hospital facilities unavailable. This guideline outlines an evidence-based approach to delivering best practice care using well established models that are already widely used, but may have been limited or restricted in UK practice.

This guidance will be kept under regular review as new evidence emerges. If you would like to suggest additional areas for this guidance to cover or any clarifications required, or to submit new evidence for consideration, please email COVID-19@rcog.org.uk. Please make it clear that your email relates to this piece of guidance. Note, we will not be able to give individual clinical advice or information for specific organisational requirements via this email address.

I.1 The virus

Novel coronavirus (SARS-COV-2) is a new strain of coronavirus causing COVID-19, first identified in Wuhan City, China. Other coronavirus infections include the common cold (HCoV 229E, NL63, OC43 and HKU1), Middle East Respiratory Syndrome (MERS-CoV) and Severe Acute Respiratory Syndrome (SARS-CoV).

I.2 Guidance for people in the UK

Everyone should continue to follow the guidance issued by the UK Government found [here](#).

I.3 Regulation of abortion care services

In England and Wales, abortion care is regulated by the Abortion Act 1967 which determines when and where an abortion can take place, and who can provide care. In Scotland, abortion is also regulated by the Abortion Act 1967, but responsibility is now devolved to the Scottish Government. In Northern Ireland, a new legal

framework for abortion care was established on Tuesday 31 March 2020 made necessary by the Northern Ireland (Executive Formation etc) Act 2019. Abortion services are currently developing in Northern Ireland, with some services (particularly early medical abortion services) now available for girls and women.

The regulations around abortion care differ in each of the four nations. Scotland (since 2017) and England and Wales (since 2018) have permitted the use of misoprostol, the second drug used in an early medical abortion regimen, at home.

In response to the COVID-19 pandemic, the Department of Health and Social Care in England and the Welsh Government issued new and temporary approvals to permit the home use of mifepristone as well as misoprostol up until 10 weeks' gestation. These new approvals permit medical practitioners to prescribe from home. The Scottish Government has also issued an approval which allows home use of mifepristone and misoprostol without defining a gestation. Where a gestational limit is not defined by law, healthcare professionals may judge when an early medical abortion at home is appropriate.

In order to fulfil the statutory requirements of the Abortion Act 1967, an abortion must still be signed-off by two registered medical practitioners (RMP) in England, Wales and Scotland. [Guidance from the Department of Health and Social Care \(2014\)](#) states that a registered medical practitioner can rely on the information obtained by other members of their team when certifying an abortion. This certification can be performed remotely, including through use of their electronic signature applied to the HSA1 form.

In England, Wales and Scotland, providers can offer a complete early medical abortion service with consultation taking place via video or teleconferencing, and a treatment package sent to the woman's home by courier, post or by other means. In Northern Ireland, there is variation across the province but a remote consultation can be conducted with a brief in-clinic interaction to take the mifepristone and collect the remaining medications to use at home. These models will help to limit the spread of COVID-19, support women to access abortion care if they are self-isolating and help providers to adhere to government guidelines on social distancing. Providers should organise their services to adopt these new models of care.

It should be a priority for each of the four nations to consider any emergency legislative or regulatory changes which would enable greater use of telemedicine to provide abortion care, and ease restrictions on which healthcare professionals are permitted to certify an abortion. Where possible, the four nations should align their approaches to ensure consistency and minimise confusion.

For more information on each of the legal and regulatory frameworks in your nation:

- [Temporary approval of home use for both stages of early medical abortion in England](#)
- [Temporary approval of home use for both stages of early medical abortion in Wales](#)
- [Temporary approval of home use for both stages of early medical abortion in Scotland](#)
- [A new legal framework for abortion services in Northern Ireland](#)

I.4 Priority

- **Abortion care is an essential part of health care for women: services must be maintained even where non-urgent or elective services are suspended.**
- **Abortion is time-sensitive, and attention should be paid to providing care as early as possible given gestational limits.**
- **Access to abortion care should be organised so that delays are minimised.**

Abortion is an essential part of women's health care.¹ In England and Wales, 205,295 abortions were performed in 2018,² and an estimated one in three women will have an abortion by the age of 45 years.³ Abortion is safer the earlier in gestation it is performed.⁴ Mortality and morbidity with abortion is low and lower than continuing a pregnancy to term, but increases exponentially for each additional week of pregnancy after 8 weeks' gestation.⁵

There is evidence that abortion rates are similar whether access to abortion is freely available or restricted, but where access is restricted, women are more likely to resort to unsafe abortion outside of medical regulation which is likely to be detrimental to the health of the woman and require more specialist care from the healthcare system.⁶ It is not known how many women access unregulated sources of abortion medication in the UK, but pathways modifications, following the approval of early medical abortion at home, make it likely this group will now access care through abortion care providers. The benefits of such vulnerable women engaging

with abortion care providers are significant – the safeguarding processes may detect inaccurate dating of last menstrual period (LMP) and could identify victims of abuse who would otherwise have gone undetected.

Guidelines from the National Institute of Health and Care Excellence (NICE) on abortion care state that women should be able to self-refer and that there should be minimal delay in the abortion process.⁷ This is due to reduced risk of morbidity with the availability of medical abortion at home at earlier gestations and better patient care. In the 6 weeks following implementation of telemedicine pathways in England and Wales, it is known that 15,138 women received remote access abortion care using no-scan pathways through the independent service providers.⁸ Although figures from NHS Trusts are not currently available, in 2018 they provided 28% of abortion care in England and Wales.² Assuming NHS contribution to the total provision of abortion care was limited to 10% owing to the pandemic or failure to implement telemedicine pathways, it can be estimated that at least 16,500 women would be able to access essential health care in the safety of their own homes at a time when many NHS services were suspended and lockdown was in place.

Delay in providing abortion care may mean that thresholds of gestation set out in legal and regulatory frameworks are crossed. Crossing such thresholds will prevent women being eligible for early medical abortion at home, will increase demand on operating theatres, and at more advanced gestations, may result in more frequent complications, requiring specialist skills that are already overstretched. Delays in obtaining an abortion can be distressing for women, especially as presentations at later gestation are often from women in high-risk groups, women with significant comorbidities, or those who are seeking termination for reasons of fetal anomaly. The impact of not being able to obtain an abortion can be devastating and can lead women to source abortion through unregulated routes.

2. Pathways to minimise COVID-19 exposure for women and staff

2. Pathways to minimise COVID-19 exposure for women and staff

- Organise early medical abortion services to be provided via video or teleconferencing consultations and postal delivery (or other delivery method) of a treatment package.
- Women who are self-isolating and suitable for an early medical abortion at home should be treated without the need to visit a clinic in person (e.g. by posting the required treatment pack) and without delay. At later gestations, providers should explore if assessment can be done in person as soon as possible, in adequate isolation.
- Self-referral to abortion care is recommended by NICE and can be done remotely.
- Maximise the use of remote consultations (e.g. via video or telephone) to provide pre- and post-abortion care and assessment.
- Women requesting an early medical abortion should only be required to attend in person where the benefit of doing so outweighs the risk of COVID-19 exposure and transmission.
- Provide abortion care without routine pre-procedure ultrasound where appropriate.
- Provide abortion care without routine pre-procedure blood testing.
- If screening for sexually transmitted infections (STIs) is required, offer this remotely (e.g. via a web-based home testing service) when possible.
- Offer discussion of contraception options – if appropriate, include contraception in pack.
- For medical abortion, provide a further dose of misoprostol 400 micrograms for use if abortion has not occurred after 3–4 hours. If approval is given for misoprostol use at 10–12 weeks in any nation, provide 800 micrograms as either a single second dose or two further 400-microgram doses.
- Ensure women have adequate analgesia (e.g. ibuprofen) and offer additional medications (e.g. co-codamol 30/500 or codeine 30 milligrams) to be used as back-up analgesia.

- **Post-abortion care can be provided remotely and women booked for ultrasound scan if required.**

Undertaking abortion assessments by phone or video call is recommended by NICE (1.1.9).⁷ Provided appropriate information governance safeguards are in place, a woman may provide their medical and other history using an online history form transmitted to the provider prior to the consultation.

Consultations can take place via video-link or on the telephone, but experience from providers who regularly use telemedicine shows that both women and staff value video-links (see Resources section below), with solutions that can be delivered from a mobile phone without the need to download additional software being easiest to implement. Providers need to ensure the woman has adequate privacy at the start of the consultation.

2.1 Ultrasound scanning

Previous guidance from the RCOG and international bodies including the World Health Organization has advised that routine pre-abortion ultrasound scanning is unnecessary.⁹⁻¹² A recent multicentre project tested the hypothesis that women with pregnancies at 8 weeks' gestation or less can be safely provided with early medical abortion without a routine ultrasound.¹³ In total, 365 participants provided enough follow-up information for analysis, in which 95% (n=347) had complete abortion without additional treatment, 1% (n=3) required a surgical aspiration and 1% (n=3) had a serious adverse event (2 hospital admissions for heavy bleeding managed with aspiration and 1 diagnosis of persistent gestational sac 19 days after enrolment) which were unlikely to have been prevented by conducting a pre-procedure ultrasound. Other studies have provided evidence that early medical abortion without routine ultrasound scanning can be safely provided remotely up to 70 days' gestation and beyond.^{14-16,45}

2.1.1 Gestation assessment

Most women can determine the gestational age of their pregnancy with reasonable accuracy by LMP alone. A prospective trial of 4,484 women seeking early medical abortion found that 1.2% of women whose LMP dated them to less than 10 weeks had ultrasound dating of over 10 weeks.¹⁴ Inadvertent treatment of gestations over 10 weeks is inevitable in some women, although the consequences for most are unlikely to be significant.¹² Underestimation of gestational age could result in a failure of the abortion (the likelihood of which may be mitigated by offering additional doses of misoprostol – see section 2.4), and bleeding, cramping and distress being greater than expected.⁴⁴ After 9 weeks, the products of the pregnancy may be more visible at the time of the abortion.¹⁷ Nevertheless, the overall success of self-managed abortions by women at >12–24 weeks' gestation is 93%,⁴⁶ with efficacy and safety similar to that expected in earlier gestation.¹²

More evidence is needed as to whether any specific aspects of a woman's menstrual history may be associated with higher-than-expected gestation. A peer-reviewed American consensus guideline does not exclude women who report menstrual irregularity or recent use of hormonal contraceptives so as not to limit access to telemedicine unnecessarily.¹² Where uncertainty exists, other factors in the woman's history may help to determine whether a scan ought to be discussed and considered – for example the timing of pregnancy testing and onset of pregnancy symptoms, dates that contraceptive pills were missed or when intercourse occurred.

There is no requirement for an ultrasound to determine gestation age for a doctor to authorise an abortion under the requirements of the Abortion Act 1967. There should be no legal consequences for either the clinician or the woman, even if gestation is unexpectedly advanced, when they can demonstrate that they have acted 'in good faith'. Data from the first 6 weeks of telemedicine suggests that the risk of inadvertently treating late gestations is low but given the high volume of cases, even low event rates will occur. It should be noted that terminations of pregnancy (of any gestation) carried out within the law are not subject to a child death review.⁴⁷

2.1.2 Ectopic pregnancy

Some providers use ultrasound to ensure the pregnancy is not ectopic in location. NICE guidance states that abortion can be performed without definitive evidence of an intrauterine pregnancy (1.7.1).⁷ In addition, routine screening of symptom-free women is associated with a high false-positive rate when the prevalence of ectopic pregnancy is low, as is the case in the abortion-seeking population.^{15,16,18} Ultrasound is of low sensitivity for exclusion of ectopic pregnancy when women present at very early gestations (and earlier presentation is a likely consequence of telemedicine due to better access and more efficient care pathways). Taking a history and a symptom-based approach, with an ultrasound if indicated, is consistent with NICE guidance on the diagnosis and management of miscarriage and ectopic pregnancy.¹⁹ The American consensus guideline notes that substantial data and current clinical guidelines support treatment of women in whom ectopic pregnancy has not been definitively excluded as it can be detected and managed safely afterwards.¹² Proceeding with early medical abortion with no scan (or if scanned with no evidence of intrauterine pregnancy) may permit earlier diagnosis of a developing ectopic pregnancy owing to increased surveillance and index of suspicion. It is essential that women are informed of the rare incidence of an ectopic pregnancy, that the process of an early medical abortion will not affect it, and that it is important they seek medical help if pain worsens after the abortion or if they have a persistently positive pregnancy test.

2.1.3 Indications for ultrasound

Reasons for undertaking an ultrasound before abortion in the first trimester include:^{7,9,20}

1. If a woman is unable to provide either a known date of conception or LMP of reasonable certainty to be able to offer care within thresholds of eligibility or skill (e.g. 10–12 weeks for an early medical abortion under current regulations; 14 weeks for a vacuum aspiration).
2. History or symptoms suggestive of a high risk of ectopic pregnancy; for example:
 - Presence of unilateral abdominal pain and vaginal bleeding/spotting which could indicate an ectopic pregnancy.⁹
 - An intrauterine device in situ removed within the past 4 weeks.
 - Prior ectopic pregnancy.
 - History of tubal damage or surgical sterilisation.

If a woman has already had an ultrasound, providers should accept the report from other services provided they meet standards of scanning for the UK and not repeat the scan unnecessarily.²¹ Ultrasound is not routinely required in the second trimester unless more accurate gestational age determination is needed to plan cervical preparation or other aspects of the procedure or to identify abnormal placentation in women with prior caesarean births.

2.2 Blood testing

A robust pre-abortion assessment does not always need to include blood testing. Routine blood tests such as full blood count or testing for haemoglobinopathies are not recommended by NICE²² and should only be considered if there are specific clinical concerns. It is not cost-effective or necessary to 'group and save' when providing abortion care.¹⁰

Determination of rhesus status (RhD) is not required before early medical abortion (NICE 1.3.2)⁷. For surgical abortion, NICE guidance recommends this after 10 weeks but only to 'consider' determining RhD status under 10 weeks (1.3.3). Providers should consider whether the risk from COVID-19 outweighs the benefit of receiving anti-D immunoglobulin – for example, if testing or administration would require additional face-to-face

visits. Providers should discuss the absence of evidence with women and come to a shared decision.

Recent data from flow cytometry suggest that feto-maternal haemorrhage in early pregnancy is less than had been supposed, especially where sharp curettage is not used in surgical procedures. The NICE guidance on miscarriage states that anti-D is not required for medical management of missed miscarriage up to 13 completed weeks (13+6).¹⁹

The NICE abortion care guideline noted that assessment for anti-D should be based on an individual woman's risk benefit profile and taking note of women's preferences⁷ (evidence review C). For example, anti-D is more likely to be beneficial in later gestations, in women who are likely to want future pregnancies, and where there would be no delay to their care by testing. In contrast, for same-day procedures where aspiration is used, especially at earlier gestations and where the woman considers her family complete, an assessment may conclude that anti-D is not warranted.

If a woman at any gestation is certain that she has completed childbearing and understands the risks of not receiving anti-D then there is no benefit in testing. Overall, should testing be considered necessary, clinicians should discuss the issues with the woman and weigh the risks of COVID-19 transmission, or delay to care that may result, against any benefits of checking RhD status.

2.3 Sexually transmitted infection screening

If a screen for STIs is indicated ²⁴ (or a chlamydia screen recommended as per the national screening programme best practice), ²⁵ a web-based home testing service offers the best solution, although availability will vary owing to commissioning variations.

2.4 Early medical abortion

The regimens and process of medical abortion is set out in more detail in the NICE guideline and RCOG, FSRH and BSACP Clinical Guidelines for Early Medical Abortion at Home – England.^{7,26} Effective regimens for medical abortion include:

- Mifepristone 200 mg orally, followed 24–48 hours later by misoprostol 800 micrograms given by the vaginal, buccal or sublingual route.
- If abortion has not occurred, a further dose of misoprostol 400 micrograms after 3-4 hours can be administered.²⁷ If approval is given for 10–12 weeks in any nation, 800 micrograms can be taken as

either a single second dose or two further 400-microgram doses.¹² Providers should consider offering this to women at the outset.

Medical abortion is effective at all gestations, but additional doses of misoprostol are often needed to maintain high levels of effectiveness as gestational age advances (NICE 1.10.1).⁷ An observational study of 4,132 women having medical abortion up to 9 weeks' gestation found that the likelihood of complete abortion decreased with increasing gestation ($p < 0.0001$).⁷ The addition of a second dose of 400 micrograms misoprostol if required reduced failure rates (odds ratio [OR] 5.88, 95% confidence interval [CI] 1.30–26.59) and removed the effect of gestation on success rates.

Given that it is especially important to reduce contact during the COVID-19 pandemic, providing a second dose of misoprostol for women to use 3–4 hours after the first dose if they have completed the abortion would seem prudent. If units do not have supplies of one additional dose of 400 micrograms and are unable to pack down their stocks of 800 micrograms, they should give two sets of 800 micrograms and advise the women to use this for a second dose if required. Higher doses (either one of 800 micrograms or two of 400 micrograms) may be particularly beneficial after 10 weeks if home use approval is granted at these gestations.

Women should be counselled on what to expect during and after the medications are taken. Guidance on counselling points are addressed in the NICE guideline and associated decision-making tool.¹⁷

Pain relief should always be discussed, offered and provided, if requested. There is good evidence that non-steroidal anti-inflammatory drugs (NSAIDs; e.g. ibuprofen 400–800 milligrams) are the most effective for abortion-related pain. Paracetamol is less effective than ibuprofen but can be used if NSAIDs are contraindicated or poorly tolerated.²⁸ Women may find non-pharmaceutical measures, such as heat packs, useful.²⁸

Occasionally and not always predictably, women may find the pain from medical abortion to be particularly distressing. Therefore, providers should offer a stronger analgesic such as codeine or co-codamol 30/500 as back-up analgesia. If the woman cannot obtain over-the-counter analgesia, for example because she is self-isolating or where supplies are not available in the shops, they should be provided in appropriate quantities.

Assessment of post-medical abortion outcome should be carried out with the use of a low-sensitivity pregnancy test⁷ (NICE 1.14.2). Women should have the choice of self-assessment or remote assessment (for example, telephone or text messaging) as an alternative to clinic follow-up.^{7,42,43} If low-sensitivity pregnancy tests become unavailable, a high-sensitivity pregnancy test may be used 3–4 weeks after treatment.⁷

For a home-use treatment package, providers should package the medicines needed (i.e. mifepristone, misoprostol, any analgesia or anti-emetic indicated), a low-sensitivity pregnancy test (with instructions for use), written advice and a plan for follow-up or self-assessment. The treatment package can be sent by mail or courier. Where home use is not permitted, or if a woman would like to collect her treatment package, this should be done with minimal contact and from a reception area following assurance of identification.

Women should be given the option to discuss contraceptive options. Providers should offer to include a method of contraception in the treatment pack (for example, an oral contraceptive), especially when restrictions on travel and available services will impact on a woman's ability to access long-acting reversible contraception.

**3. Abortion
care for women
with suspected
or confirmed
COVID-19**

3. Abortion care for women with suspected or confirmed COVID-19

Staff should follow the latest national guidance from Public Health England (PHE) and locally agreed policies on infection prevention and control (IPC), including the appropriate use of personal protective equipment (PPE).

All women should be screened for symptoms of COVID-19 (a high temperature; a new, continuous cough; or loss or change to sense of smell or taste) when presenting for abortion care. If a woman has symptoms, or has tested positive, a risk assessment should be undertaken to determine if the abortion can be safely deferred for the isolation time recommended by PHE (persistent cough is not a significant factor in determining recovery).

3.1 Self-isolation due to contact with suspected COVID-19

If a woman is suitable for an early medical abortion at home, this should be organised without the need for attendance in person (e.g. by posting the required treatment pack) and without delay (see summary of early medical abortion care on page 2.)

Women who are self-isolating for 2 weeks due to household contact should be risk assessed for symptoms if face-to-face assessment is required. Care should be booked for when the isolation period is over unless the gestation is uncertain, and the delay may result in a woman not being able to access abortion care (e.g. owing to the pregnancy being over a legal threshold).

If the abortion cannot be deferred and face-to-face contact is necessary, providers should advise the woman to inform her healthcare professional should she develop any new symptoms before her clinic appointment, to allow for correct IPC measures to be taken. This may mean transfer to a unit that can care for women with COVID-19.

3.2 Suspected/confirmed COVID-19

If a woman is suitable for an early medical abortion at home, she should be advised to take this pathway if she has no symptoms or mild symptoms of COVID-19 (persistent cough is acceptable), and before the pregnancy reaches 10 weeks' gestation.

If the abortion cannot be safely deferred and face-to-face contact is necessary, providers should request that the woman attend at a specific time (typically end of clinic, in a location that is equipped to care for COVID-19 patients) so correct IPC measures can be put in place. The woman should be given a surgical face mask to wear and asked to wash her hands on arrival. If the woman requires face-to-face assessment but the pregnancy is likely to be under 20 weeks' gestation, care should be booked at least 7 days since the illness started (unless she continues to be unwell, excluding a persistent cough).

If abortion cannot be safely deferred, providers should assess and discuss with the woman whether she would be best cared for with a medical or surgical abortion (e.g. if there are suitable facilities in an obstetric unit or gynaecology ward) in consultation with infectious disease, anaesthesia and infection control colleagues. If she is unwell, care should be co-ordinated through a multidisciplinary team.

If surgical abortion is performed:

- Perform vacuum aspiration under local anaesthesia or intravenous sedation where feasible to avoid the need for general anaesthesia.
- Consider whether spinal anaesthesia or intravenous sedation would be more appropriate than an anaesthetic requiring ventilation.
- Consider checking full blood count, clotting and blood group if unwell.
- Ensure that best practice is followed to reduce risk of transmission of infection (e.g. limit number of people in theatre, use PPE and decontaminate area after procedure as recommended by PHE).

If the pregnancy is at risk of being over 23 weeks' gestation when the COVID-19 concern resolves (including time needed for cervical preparation):

- Admit and treat in facilities that can manage COVID-19 patients and where the staff have been trained to support women undergoing an abortion.
- Initiate medical or surgical treatment once afebrile.
- If either clinical condition prevents an abortion or the woman is approaching the legal limit, perform feticide and manage the abortion after her condition stabilises.

- For complex cases or later gestations, liaise as appropriate with specialist centres, fetal medicine units, anaesthetists, obstetric units and infection control experts.

Current evidence, based on a small number of cases, suggests that COVID-19 is not present in genital fluid, although it is too early to know whether vertical transmission is a significant risk.²⁹⁻³² Unless the anaesthetic used involves ventilation, neither abortion nor obstetric procedures are classed as aerosol generating procedures which carry the highest risk of transmission of respiratory viruses.³³

In accordance with national guidance, recommended PPE for staff caring for women having an abortion with suspected or confirmed COVID-19 are disposable gloves, long-sleeved fluid repellent disposable gown, fluid resistant surgical mask and disposable eye protection.³³ Where the woman has no symptoms of COVID-19 or has a negative test, providers should follow locally agreed PPE protocols.

For women who have symptoms of COVID-19 or confirmed infection, it is best to delay treatment until they have recovered and are no longer infectious where possible. However, if that delay would result in abortion becoming unobtainable owing to gestation, the abortion should proceed in a unit where appropriate IPC measures can be provided. The best method of abortion, whether medical or surgical, will depend on the woman's health and the skills and facilities available.

Other considerations include:

- Anaesthesia that does not require airway management is likely to reduce the risk of transmission of infection.
- There are some case reports that clotting, bleeding and thrombosis may be deranged in severe COVID-19 infection (albeit not reported in gynaecology), and therefore pre-operative investigations may be prudent, with thromboprophylaxis considered post-operatively.
- If the woman's clinical condition prevents abortion, and she risks exceeding the gestation limit, feticide should be performed in collaboration with local fetal medicine services if necessary, to enable delay in the procedure to evacuate / empty the uterus.

4. Consent and safeguarding with remote consultations

4. Consent and safeguarding with remote consultations

- A woman must be given enough information and time, including the opportunity to ask any questions she may have, so that she can give informed consent to proceed with the abortion.
- Written information should be provided or available prior to the consultation; this can be e-mailed, or a link provided to an online source.
- Consent does not have to have a written signature, but an entry must be made in the clinical notes that the woman has given informed consent.
- Safeguarding is an essential part of the assessment for abortion care, but where a more detailed assessment is required individualised judgement should be used to determine whether remote consultation is suitable. This also applies to vulnerable women and children under the age of 16.
- Where English is not the first language, care should be taken to establish that the woman has understood the process (via telephone interpreter, if necessary) and has had the opportunity to ask questions.

The process of obtaining consent should follow normal best practice as detailed in GMC guidance.³⁴ This should include the information discussed; any specific requests by the woman; any written, visual or audio information given to the woman; and details of any decisions that were made. The consent must be recorded in the woman's medical records and include the key elements of discussion, but it does not have to be on a specific form or signed by the woman – the woman can give consent verbally.³⁴ Consent can be obtained remotely using telephone, internet or video link providing that it is appropriate to the woman and meets the same standards for consent as would be undertaken in a face-to-face encounter.³⁵

The RCOG states in its guideline “Obtaining Valid Consent”,³⁶

“It is a common misconception that consent has to be written for it to be valid. A key issue in taking consent is the recognition of the fact that consent is a process that involves supplying the patient with enough information to make a fully informed decision. Therefore what matters is not necessarily the completion of a form but during the process of taking consent that the medical records contain clear, concise notes that cover the nature of the procedure concerned, risks, benefits and alternatives, along with a record of fears or concerns raised by her.”

Safeguarding is an essential part of the assessment for abortion care, and providers should follow their processes and assess each case on an individual basis. However, there is no automatic need to have to do this in person if adequate assessment is possible via remote consultation, although it is recommended that this should be tailored to the individual.³⁴ The clinician should be confident that the woman is not being coerced and that she is able to discuss any concerns privately. Remote consultation may enable vulnerable women, for example those with a coercive partner, to access care more discretely, especially during COVID-19 and lockdown.

**5. Other pathways
to manage
resources and
workload**

5. Other pathways to manage resources and workload

- Maximise use of nurse delivered care within the constraints of the current legal framework.
- Consider surgical abortion with access to pain relief that does not require theatre facilities or anaesthetic support.
- Consider extending services for medical abortion to the second trimester.

For women who are beyond the threshold for an early medical abortion at home (i.e. up to 10 weeks in England and Wales and 12 weeks in Scotland) or who request vacuum aspiration, there are a number of other options which can be made available.

Nurses safely and effectively provide abortion care in many healthcare settings around the world and there is evidence that such care is preferred by women. Their role is supported by the NICE abortion care guideline (1.1.11).⁷

Surgical abortion can be safely provided outside of an operating theatre, and without requiring anaesthetic support, by using effective local anaesthetic techniques (e.g. paracervical block),^{37,38} conscious sedation or intravenous sedation.^{7,39,40}

Medical abortion regimens using 200 mg oral mifepristone, and misoprostol are effective and appropriate at any gestation.^{7,9} Although women cannot take abortion medication at home after 9+6 weeks in England and Wales, it may be appropriate to provide the medication within an approved premises and immediately discharge the woman to complete the medical abortion at home. This would need to be discussed with the woman on a case-by-case basis with an individual risk assessment (balancing factors such as gestation, travel time, support at home, pain management, concern at visualising a fetus) to enable her to make an informed choice. Many trusts only offer medical abortion in the second trimester for termination in cases of fetal anomaly. However, if theatre capacity becomes increasingly restricted, services should consider retaining or expanding access to second trimester abortion services for all women.

Second trimester medical abortions can be completed as day cases when the interval between mifepristone and misoprostol is 36-48 hours (mean induction to abortion time of 6–8 hours).⁴¹ Feticide is recommended at 22 weeks (22+0) or greater;¹⁰ this should be facilitated collaboratively with fetal medicine services.

6. Collaboration

6. Collaboration

- Abortion providers should collaborate and support each other to ensure available resources are used most effectively.
- Commissioners should ensure there are no barriers to collaboration and shared care pathways.
- Where an abortion provider has to temporarily suspend services (e.g. to permit deep cleaning) they should alert nearby providers and where appropriate organise transfer of care of existing patients.
- Wherever possible, providers should recognise the processes and documentation of providers transferring care or seconding staff to them (e.g. assessments, safeguarding outcomes, consent forms, staff accreditation and credentials) to minimise duplication of work.
- Providers should minimise any distress caused by a transfer of care and ensure this is discussed with women, offering support where needed.
- During the pandemic, to reduce hospital attendance, independent sector providers (ISPs) may provide abortion services to women with a complex comorbidity where appropriate. This can be possible by collaboration with the specialist team involved in the woman's care.

Most abortion care in England and Wales is provided by ISPs: the British Pregnancy Advisory Service (BPAS), Marie Stopes International UK (MSI) and the National Unplanned Pregnancy Advisory Service (NUPAS).

ISPs mostly provide care from community centres and therefore cannot manage complex cases or care for women who need the resources of an acute hospital (e.g. overnight admission, high dependency care, laboratory facilities). However, by offering care outside of NHS Trusts, ISPs relieve pressure on hospitals, possess efficient systems that include long-established centralised telephone assessment pathways and have experienced nursing and medical staff who can operate up to 23+6 weeks.

Acute trusts, faced with pressure on their beds and operating theatres, may consider collaborating with ISPs to transfer non-complex cases to their care or identify ways to share facilities or staff. This may help the trust to concentrate its resources on maintaining essential provision to women who must have care in hospital, such as those requiring isolation owing to COVID-19 or who have existing comorbidities. Although emergency

transfers following complications from the ISPs to the acute sector are rare, they do inevitably occur given the high volumes. Therefore, maintaining an emergency gynaecology service with the capacity to admit is essential.

6.1 Considering transfer of care to independent sector providers

- If the woman has not yet received care, discuss the option of other providers and support her to access their booking systems.
- If the provider has seen the woman, they should phone the ISP making it clear they have already assessed the woman (preventing the need for another appointment); relevant documents (e.g. clinical notes, HSAI form, scan or laboratory reports) should be sent electronically as directed by the ISP.

Useful contact details:

BPAS

T: +44 (0) 3457 30 40 30 W: bpas.org

Marie Stopes UK

T: +44 (0) 345 300 8090 W: mariestopes.org.uk

NUPAS

T: +44 (0) 333 004 6666 W: nupas.co.uk

Informing Choices Northern Ireland

T: +44 (0) 28 9031 6100 W: informingchoicesni.org

7. Staffing issues

7. Staffing issues

- **Staff who need to self-isolate but who are otherwise well and able to work should be supported to work from home.**

Where IT systems permit remote access, staff may be able to work from home in a range of activities that may include remote patient care, for example telephone consultations, checking and signing statutory forms or remote prescribing. Providers should ensure their IT policies regarding remote access are clear, and where possible should facilitate this.

Whilst the overarching regulations for medicines are reserved to the UK Government, the process by which medicines are prescribed is devolved to each of the UK nations, within the powers of the reserved regulations. In England, Wales and Scotland, medical practitioners can prescribe remotely, including from their own home, for the purposes of early medical abortion.

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Additional resources

Support, advice and resources are also available from:

British Society of Abortion Care Providers (BSACP) – www.bsacp.org.uk

IPAS – www.ipas.org

World Health Organization (WHO) – www.who.int/health-topics/abortion

Webinars from experienced practitioners delivering remote care are available (with thanks to and courtesy of BSACP and Gynuity):

Abortion without prior ultrasound – <https://bit.ly/2xFeboC>

Video consultation in abortion care – <https://bit.ly/2Qohd7b> (access code: GH207)

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Appendix I: Summary of previous updates

Version	Date	Summary of changes
2	31.3.20	1.3: Section updated to provide information on new regulations in England, Wales and Scotland permitting the home-use of mifepristone and misoprostol.
2	31.3.20	2.4: Additional information on when to provide a further dose of misoprostol for early medical abortion.
2	31.3.20	2.4: Additional information on pain relief options for early medical abortion.
2	31.3.20	3: New section added providing guidance for managing women with suspected or confirmed COVID-19.
2.1	9.4.20	1.3: New paragraph clarifying that two registered medical practitioners must still sign a form, agreeing that an abortion is to take place within the legal framework, but that this can be done remotely.

DISCLAIMER: The Royal College of Obstetricians and Gynaecologists (RCOG) has produced this guidance as an aid to good clinical practice and clinical decision-making. This guidance is based on the best evidence available at the time of writing, and the guidance will be kept under regular review as new evidence emerges. This guidance is not intended to replace clinical diagnostics, procedures or treatment plans made by a clinician or other healthcare professional and RCOG accepts no liability for the use of its guidance in a clinical setting. Please be aware that the evidence base for COVID-19 and its impact on pregnancy and related healthcare services is developing rapidly and the latest data or best practice may not yet be incorporated into the current version of this document. RCOG recommends that any departures from local clinical protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.

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