SIMPLIFYING MEDICAL ABORTION FOLLOW-UP + CONTRACEPTIVE ACCESS

A TOOLKIT FOR ABORTION PROVIDERS

A one-visit service delivery model for people choosing medical abortion

Gynuity HEALTH PROJECTS

INTRODUCTION

An increasing number of people seeking abortion are electing to use medications, most often mifepristone and misoprostol, to terminate their pregnancy. Giving people who choose abortion pills the option of deciding the method, timing and location of their abortion and subsequent contraception is an essential component of high quality abortion services.[1]

Simplifying medical abortion protocols and contraceptive access promises to make these options more convenient, available and acceptable. There is no medical reason to require all people undergoing a medical abortion to return to a facility to either assess the status of their abortion or, for those people who wish to start contraception immediately, to receive an implant or injectable contraceptive method.

Remote follow-up with a low sensitivity or multi-level pregnancy test and self-assessment of symptoms is safe, effective and acceptable and can be done at home[2-6]. Both contraceptive implants (Implanon or Explanon) or progestin-only injectable contraceptive (depo medroxyprogesterone acetate, DMPA) can also can be safely provided at the time the mifepristone[7-8] or misoprostol are taken[9].

WHAT IS THE PURPOSE OF THIS TOOLKIT?

This guide provides resources and tools developed as part of an implementation project designed to help providers and health care systems introduce a service delivery protocol that allows people choosing medical abortion the option to receive an implant or injectable contraceptive at the time of mifepristone administration and to follow up their procedure at home. Abortion providers and clinic systems may find this guide and tools useful as they begin or adapt a service delivery protocol offering people the option of a 'one visit' medical abortion.

ACKNOWLEDGEMENTS

This toolkit was created as part of a pilot project at two family planning clinics. We would like to thank the staff and administrators who helped to implement and evaluate the project components.

1.

BUILDING SUPPORT

for a Simplified Medical Abortion Protocol

MAKING POLICY

Provision of information about and access to effective methods of contraception are essential components of high quality abortion services[1]. Simplified service delivery protocols that do not require people choosing medical abortion to return to the facility for follow-up care, or to initiate contraceptive methods such as implants or injectables, are now included in most US professional guidelines for abortion provision. **Adopting these recommendations at the facility level is the first step to making these options available to people choosing medical abortion and ensuring more patient-centered care.**

MAKING CHANGE

Even with supportive policies, an implementation plan that makes the service delivery changes easy for everyone in the facility — from staff answering the phone to the clinician providing care and the accountant managing the billing — are critical to ensure all eligible patients are offered these service delivery options.

This section includes a list of **Resources** and **Frequently Asked Questions** that may be helpful to encourage policy change at your facility if policies supporting same-day start of implants and injectable contraceptives or remote follow-up are not already in place.

Once supportive policies are in place, the **Discussion Guide** may be helpful to initiate conversations with all staff in order to better understand potential supports for, or barriers to, implementing these changes.

> Moving from policy to implementation requires a plan. Our implementation project identified three key strategies to aid providers and health care systems to offer a One and Done simplified service delivery protocol to people selecting a medical abortion.
>
> —clinic worker
> this and that clinic

FREQUENTLY ASKED QUESTIONS (FAQ)

Why should providers offer contraceptive methods at the time of the medical abortion?

Giving people options to choose the method, place and timing of their abortion and contraception are markers of high quality abortion care. People seeking an abortion may prefer to receive a contraceptive method at the time of their abortion as it may help to reduce the inconvenience and extra expenses associated with an additional facility visit including lost wages, travel and childcare expenses. Women return to ovulation quickly after abortion and post-abortion contraception may help prevent a future unintended pregnancy. [10]

When can providers initiate contraceptive methods after medical abortion?

All short-acting contraceptive methods including condoms and oral contraceptive pills can be provided at the time of the medical abortion. Some highly effective long-lasting methods can also be offered on the day of mifepristone administration, including contraceptive implants and injectables (DMPA).

Professional guidelines from the National Abortion Federation (NAF), American College of Obstetricians and Gynecologists (ACOG) and the Society of Family Planning (SFP) allow for "quick start" or the insertion of implants and initiation of DMPA on the day of mifepristone. Intrauterine devices (IUDs), one of the most popular long-term methods, cannot be placed until the abortion is complete and therefore not on the day of mifepristone.

Will starting implants or injectable contraceptives at the time the medical abortion drugs are taken impact the effectiveness of the medical abortion?

Research has shown that implants and injectable contraceptives (DMPA) initiated on the day of mifepristone administration do not impact medical abortion effectiveness.[7,8] The risk of continuing pregnancy after mifepristone-misoprostol medical abortion is slightly higher when DMPA is administered on the day of mifepristone compared to after the abortion is complete. However, this increased risk of continuing pregnancy is small (0.4%).

There was no difference in medical abortion effectiveness when DMPA was administered at the time of misoprostol administration.[9]

New evidence suggests that women can self-administer DMPA at a time of their choosing, further expanding access and convenience. 11 After medical abortion, the timing of administration of DMPA can be based on the person's informed choice.

FAQs continued

Do people need to return to the clinic for confirmation of their abortion status after medical abortion?

The main aims of the follow-up visit after medical abortion are to confirm that the pregnancy is not continuing, to identify complications and to detect ectopic pregnancies not identified at the initial screening.

Research and current clinical guidelines from NAF, ACOG and SFP support the use of a self-assessment of symptoms and urine pregnancy test, both of which can be performed at home, to determine when additional care is needed post-abortion.

How can we communicate with people about their abortion after they leave the facility?

Providers may communicate with patients post-abortion using a variety of different technologies, depending on provider capability and patient preference. Research has demonstrated that follow-up may be effectively conducted by phone, text, email or other telehealth methods.12-14

Communication may be initiated either by the provider or the patient. Clinic systems have employed call center staff or clinicians, as available, to address patient questions and concerns. Patient-controlled follow-up is now widely used in clinic systems in the US and many European countries.

For More Information

National Abortion Federation. Clinical policy guidelines. Washington DC: National Abortion Federation. 2020

American College of Obstetricians and Gynecologists. Practice Bulletin No. 143: Medical management of first trimester abortion. Obstet Gynecol 2014: 123: 676-92.

Raymond EG, Grossman D, Mark A, et al. Commentary: No-test medication abortion: A sample protocol for increasing access during a pandemic and beyond. Contraception. 2020;101(6):361-366.

STAFF-GUIDED CLINIC ASSESSMENT

Assessing Need

1. Have patients choosing medical abortion previously requested to start injectables or implants on the day of mifepristone administration? Were they able to obtain the service? Why or why not?
2. Do you currently give all or some patients the option to follow up their medical abortion at home? If not, roughly how many of your patients currently return to the facility for follow-up?

Scheduling

1. Does the scheduler ask about desire for contraception at the time the abortion appointment is scheduled?
2. Are callers asked about insurance coverage for abortion and contraception at the time of making an appointment for a surgical or medical abortion?

Pre-abortion counseling

1. What type of information and counseling do people receive about their contraception options on the day of their abortion during the "pre-abortion information session"?

Logistics

1. Are implants or injectable contraceptives provided in the same room where medical abortion patients consult with clinicians?
2. Are implants or injectable contraceptives always on hand on the day of mifepristone appointments?
3. Do you provide a pregnancy test to take at home to individuals who opt for home follow-up?
4. Is post-abortion communication initiated by the provider or the patient?
5. Who does or could make follow-up calls if provider-initiated follow-up is preferred?

STAFF-GUIDED CLINIC ASSESSMENT continued

Monitoring and Evaluation

1. How are peri-abortion contraceptive implant insertions or injections documented in your paper or electronic medical record?
2. Is there a place to document whether or not a patient returned for a scheduled follow-up visit and/or had a phone consultation with health center staff?
3. Do you currently collect data on where women returned for follow-up (i.e. if they go to a different clinic for follow-up or contraceptive care)

Reimbursement

1. What are the reimbursement practices for abortion services and contraceptive implants and injectables when provided separately?
2. Do you routinely conduct pre-verification of insurance coverage for contraception for people choosing medical abortion? If not, what would be a potential barrier to implementing this practice?
3. Have insurers rejected claims for peri-abortion contraception in the past? If yes, which insurers and why?
4. What is the biggest barrier to cost recovery for remote follow-up after medical abortion?
5. Is it (or would it be) a financial burden to purchase and maintain a stock of implants or injectable contraceptives for same-day insertion?

2.

PLANNING

for Implementation of One and Done

MAKING A PLAN

Moving from policy to implementation requires a plan. Our implementation project identified three key strategies to aid providers and health care systems to offer remote follow-up and same-day start of implants and injectable contraception at the time of mifepristone administration:

Adjust staffing and clinic systems for efficient and sustainable service delivery

- Initiate pre-verification of contraceptive coverage for prior to medical abortion visit.
- Available exam rooms and stocked and ready supply kits for insertion of contraceptive implants or initiation of injectable contraceptives
- Available high sensitivity pregnancy tests and information materials for patients who choose to follow-up remotely
- Staffing plan for provider-initiated remote follow-up or responding to patient questions

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Provide support for staff and people choosing medical abortion

- Develop patient education materials that help patients understand the contraceptive methods available on the day of mifepristone administration versus a subsequent facility visit.
- Develop tools to help people choosing medical abortion complete follow-up at home.
- Collaborate with staff to develop clinic flow models that are realistic and implementable

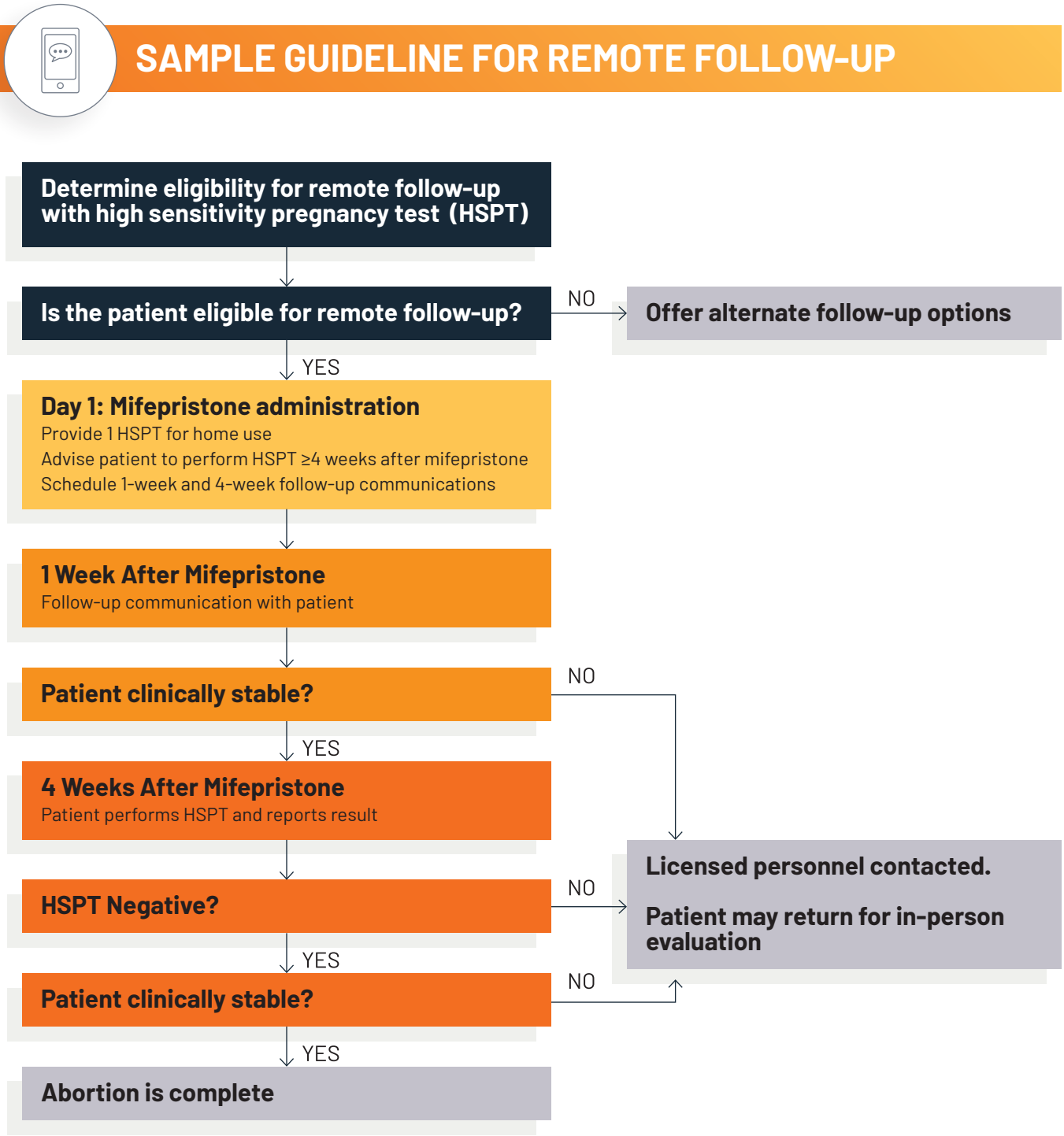
Develop data collection systems

- Help clinic staff monitor and assess implementation
- Ensure paper and electronic medical records allow for tracking the choice of timing, modality or method and location of abortion follow-up and initiation of contraception.

2. PLANNING FOR IMPLEMENTATION

This section includes a sample **guideline for remote follow-up and supply checklists** to help clinic managers and healthcare providers think through how to provide these options in their setting. We also include **sample patient information materials and clinic signage** on same-day start and remote follow-up.

SAMPLE GUIDELINE FOR REMOTE FOLLOW-UP



SAMPLE SUPPLY CHECKLISTS

REMOTE FOLLOW-UP

- [ ] High sensitivity pregnancy test (HSPT)
- [ ] Patient information sheet

IMPLANT INSERTION

- [ ] Informed consent
- [ ] Implant device
- [ ] Implant insertion instructions (see prescribing information for Nexplanon)
- [ ] Implant client education sheet
- [ ] Sterile gloves
- [ ] Chux for under arm
- [ ] Povidone iodine or chlorhexidine (if iodine allergy)
- [ ] Alcohol wipes
- [ ] Cotton swabs
- [ ] Local anesthetic 1-2% (5cc)
- [ ] Long (1.5") needle (22-27g)
- [ ] Marker
- [ ] Sterile 4x4 gauze
- [ ] Scissors
- [ ] Small adhesive bandage or Steri-strip
- [ ] Bandage to wrap arm

INJECTION OF DMPA

- [ ] Informed consent
- [ ] DMPA
- [ ] Alcohol wipes
- [ ] Cotton swabs
- [ ] Sterile 4x4 or 2x2 gauze
- [ ] Sterile syringe and needle
- [ ] Safe disposal place for used needles
- [ ] Small adhesive bandage or Steri-strip

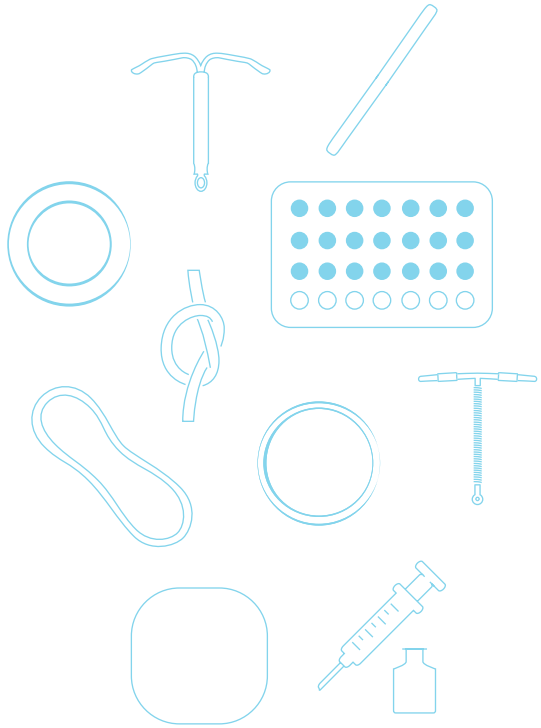
NOTES

DID YOU KNOW

that you can get any method of birth control you want after a medication abortion?

Ask your educator or provider about birth control.

If you are considering "the shot" (Depo-Provera) or a contraceptive implant (Nexplanon) for birth control, **you can even get those today, right here in clinic before you leave.**



We want to help you find the method of birth control that is best for you!

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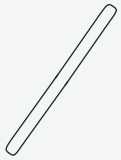
WHAT BIRTH CONTROL METHOD CAN YOU START TODAY (WHEN YOU RECEIVE THE ABORTION PILL)?

And how well does it work?

Works really, really well

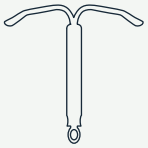
★★★★★



The Implant

You can start this method... **today**

Works, hassle-free, for up to... 4 years



Hormonal IUDs

You can start this method... at a follow-up visit

Works, hassle-free, for up to... 3-6 years

Non-hormonal IUD

You can start this method... at a follow-up visit

Works, hassle-free, for up to... 12 years

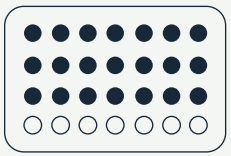
Sterilization for men & women

You can start this method... at a follow-up visit

Works, hassle-free, for up to... Forever

Works pretty well

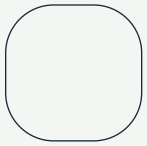
★★★★



The Pill

You can start this method... **today**

For it to work best, use it... Every. Single. Day.



The Patch

You can start this method... **today**

For it to work best, use it... Every week

The Ring

You can start this method... **today**

For it to work best, use it... Every month

The Shot

You can start this method... **today**

For it to work best, use it... Every 3 months

Not as well

★★★

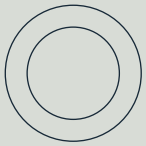
Withdrawal

You can use this method... anytime

Fertility Awareness

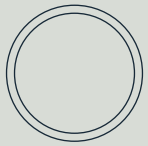
You can use this method... anytime

Use a condom with any other method for STI protection



Internal Condom

You can use this method... anytime



Condom

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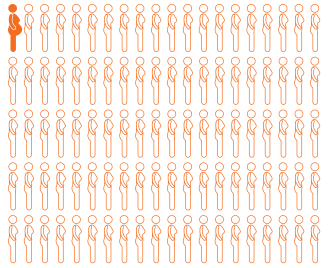
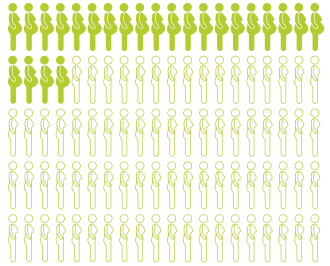
For each of these methods to work, you or your partner have to use it every single time you have sex.

What is your chance of getting pregnant?



less than 1 in 100 women

6-9 in 100 women, depending on method



12-24 in 100 women, depending on method

FYI, without birth control, over 90 in 100 young women get pregnant in a year.

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And how well does it work?

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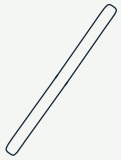

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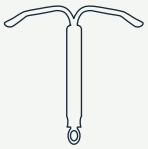

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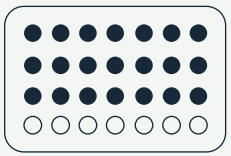

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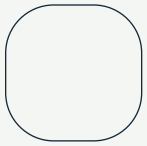

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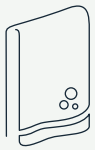
Not as well

★★★



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Fertility Awareness

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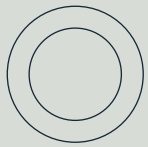

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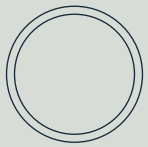

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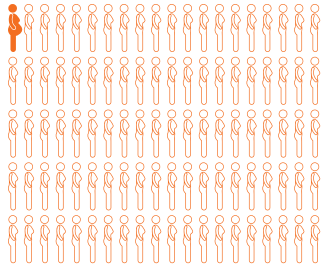

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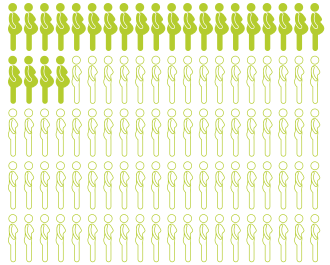

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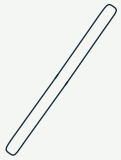

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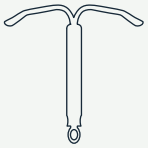

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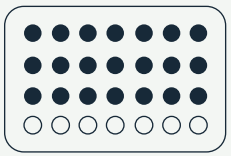

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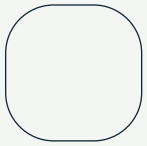

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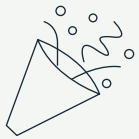

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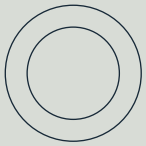

Internal Condom

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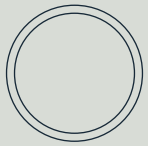

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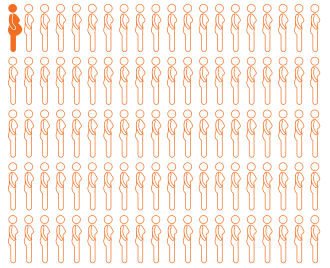
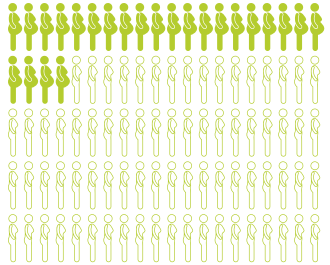
For each of these methods to work, you or your partner have to use it every single time you have sex.

What is your chance of getting pregnant?



less than 1 in 100 women

6-9 in 100 women, depending on method



12-24 in 100 women, depending on method

FYI, without birth control, over 90 in 100 young women get pregnant in a year.

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3.

MONITORING

the provision of more patient-centered care

STANDARDS

Allowing patients the option to choose how, where and when they assess the outcome of their medical abortion or initiate post-abortion contraception may allow for more patient-centered abortion care. However, there is little agreement on standard indicators for how to monitor the quality of abortion care or its 'patient-centered-ness'.15

The monitoring tools developed for this project focused on the technical quality of the service, i.e. whether providers met the standards for appropriate care. In this case, 'appropriate care' was determined to be offering all eligible patients the options of remote follow-up after their medical abortion and, for those patients who expressed an interest in a contraceptive implants or injectable, the option of same-day start.

TOOLS

We developed **a monthly checklist** to help staff monitor the implementation process and **simple indicators** to assess whether eligible or interested patients received those services. The experience in the pilot project emphasized the need to create easy tools and indicators that did not present an undue burden to staff and could be easily integrated into existing paper or electronic medical records, routine staff meetings and discussions. While these tools may help health center staff assess the implementation of the service delivery changes, further work will be needed to assess the patient experience of these changes and whether the One and Done service delivery protocol helps them to better meet their reproductive health needs and intentions.

> Moving from policy to implementation requires a plan. Our implementation project identified three key strategies to aid providers and health care systems to offer a One and Done simplified service delivery protocol to people selecting a medical abortion.
>
> —clinic worker
> this and that clinic

3. MONITORING FOR CARE

SAMPLE MONTHLY CHECKLIST

	Sometimes	Often	Always
Were all medical abortion patients in the past month provided with informational materials about options for contraception on the day of the medical abortion or a subsequent facility visit?	☐	☐	☐
Were all eligible medical abortion patients offered the option of remote follow-up?	☐	☐	☐
Was an adequate supply of pregnancy tests maintained at the facility for patients choosing remote follow-up?	☐	☐	☐
Were implant insertion and DMPA kits maintained in or near the exam rooms where medical abortion patients were seen?	☐	☐	☐
Was pre-verification of insurance coverage for contraception completed for all medical abortion patients?	☐	☐	☐

SAMPLE INDICATORS

For the month of:	
Total patients who chose medical abortion	
Number who elected to follow-up remotely	
Number who expressed interest in contraceptive implant on phone or at medical abortion visit	
Number who expressed interest in injectable contraceptive on phone or at medical abortion visit	
Number/% who received implant on day of mifepristone	
Number/% who received DMPA on day of mifepristone	
Number/% who received OCs/ring/patch on day of mifepristone	
Number/% who received other method (condom, spermicide, etc.) on day of mifepristone	

DISCUSSION QUESTIONS

1. Please describe any difficulties or challenges faced in providing same-day provision of implants and DMPA to medical abortion patients this month.

2. Please describe any successes or lessons learned in providing same-day provision of implants and DMPA to medical abortion patients this month.

3. Please describe any difficulties or challenges faced in offering medical abortion patients the option of remote follow-up after their medical abortion.

4. Please describe any successes or lessons learned in providing medical abortion patients remote follow-up.

5. Additional comments about remote follow-up for medical abortion patients:

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220 East 42nd Street, New York, NY 10017

Phone: 1(212) 448-1230 Fax: 1(212) 448-1260

Gynuity.org pubinfo@gynuity.org

@Gynuity youtube.com/user/gynuity