Medical abortion is an essential service during the pandemic

Michelle Cohen MD CCFP

Coronavirus disease 2019 (COVID-19) has had a profound effect on our health care system. In primary care, it has stymied the delivery of the preventive and routine services that keep people healthy and out of the hospital. This is no less true of reproductive health care, as evidenced by the 30% increase in calls to Action Canada for Sexual Health and Rights' hotline in late March of 2020.[1] Many callers were distressed by new barriers to contraception or abortion in the wake of the pandemic.[2]

As a family doctor who provides medical abortion services, I am acutely aware of the additional challenges the pandemic poses for reproductive health care. Meeting the comprehensive health needs of patients during these uncertain times requires a wider acceptance of medical abortion in Canadian family medicine and a greater uptake of the mifepristone and misoprostol regimen, known colloquially as the *abortion pill*.

The product combining mifepristone and misoprostol was introduced in Canada in 2017 and hailed as an important advance in equalizing abortion access.[3] The medication is 95% to 98% effective when used at up to 9 weeks' gestation, with common side effects being short-lived bleeding and cramping.[4] Yet, its uptake has been poor in primary care, with more than two-thirds of prescriptions coming from abortion clinics and with many patients reporting that their family physicians refused to prescribe it.[5] Wider acceptance of combined mifepristone and misoprostol in primary care is essential to preserving the reproductive rights of our patients.

Changes in abortion demand owing to COVID-19

For many reasons, the unmet need for abortion during the COVID-19 pandemic might increase.

Difficulty accessing contraception. In March 2020, owing to concerns about drug supply-chain disruptions, the Canadian Pharmacists Association[6] advised 30-day dispensing limits for all prescription medications, a restriction that lasted in some provinces into the summer. These restrictions increased the likelihood of missed doses of contraception. In addition, dispensing medication more frequently meant that patients paid dispensing fees more frequently, increasing the relative cost of using prescription contraception. For people who lost drug benefits owing to the economic downturn, the cost of contraception might also now be prohibitive.

Supply-chain disruptions risk many prescription contraceptives becoming unavailable for unknown periods of time. Shortages in supply can have a cascading effect if demand suddenly increases for the contraceptives still left on the market, much in the way that several recalls of ranitidine in the months before the pandemic led to increased demand and months-long shortages of other acid reflux medications.[7] The global supply chain for condoms was also disrupted by COVID-19, with halted or reduced production prompting manufacturers to warn of impending shortages.[8]

Changes in abortion demand and access. Public health stay-at-home directives have forced many to shelter in place in dangerous environments. Reports of intimate partner violence and child abuse have increased, including rates of sexual assault in the home.[9] As a consequence, we might see an increase in unintended pregnancy. To further complicate an already awful scenario, pregnancy is a well-established intensifier of intimate partner violence.[10-12] In ordinary times, a woman living in an abusive situation could more easily access her support system and her medical providers if pregnancy posed a threat to her safety. During the pandemic, however, the enormous pressure not to go out means that patients cannot access medical care in the same way, resulting in limited options for termination of pregnancy.

At the same time that we could see an increase in unintended pregnancies, abortion services themselves are being restricted. While Canadian health authorities have classed abortion as essential care, some clinics and hospitals have delayed procedures such as intrauterine device insertions and restricted abortion services. Abortion clinics continue to operate, but some have reduced their catchment area.[13] For much of rural Canada, stand-alone clinics are inaccessible, particularly now that the pandemic has made travel more difficult. Travel out of communities to access these stand-alone abortion clinics might result in women having to isolate upon their return, which can present another barrier to access. School and day-care closures present yet another barrier, because most people seeking abortion have children and might now lack child care.[14]

How the abortion pill can help

The mifepristone and misoprostol regimen solves many of the abortion access issues created by COVID-19. The medications can be taken at home, thereby eliminating the need to travel and the many complications associated with travel during the pandemic. The cost of the

prescription is covered by provincial or territorial health insurance and some national programs, so lack of drug benefits should not be a barrier.[15] The tablets can be taken discreetly in unsafe environments and the pregnancy's end passed off as a heavy period or spontaneous miscarriage by anyone facing an abuser's scrutiny.

Unlike surgical abortion, which can involve imaging, multiple visits, and close contact between health care providers and patients, medical abortion generally requires less contact and can be done without imaging in many cases. In April 2020, the Society of Obstetricians and Gynaecologists of Canada (SOGC) released new guidelines for prescribing the mifepristone and misoprostol regimen via telemedicine,[16] which are based on evidence that virtual prescribing and management of medical abortion is safe and effective.[17-20] The SOGC guidelines make these medications a viable option for patients needing a pregnancy termination, while respecting public health guidelines during the pandemic.

Primary care needs a culture shift

One of the important factors in patient access to the mifepristone and misoprostol regimen has been reluctance within primary care to prescribe it. Nearly one-third of all Canadian women will have an abortion, making it one of the most common health services in the country.[21] The view that abortion is specialized, out-of-scope care persists, despite how fundamental a service it is.[22] Medical abortion, in particular, has been hailed as a game changer in Canadian reproductive health care, a way to reverse our problem of extremely uneven access to abortion. The ability to have an abortion without traveling for hours or even days eliminates substantial geographic barriers for rural populations.[23] Primary care providers understand better than most how patients suffer when they cannot access geographically remote services. We should be embracing tools that prevent this type of suffering, especially during the pandemic when the need for abortion might be greater.

Family physicians uncertain about medical abortion should be aware of the resources and supports that exist. The SOGC offers an online course that reviews the basics of prescribing medical abortion as well as the management of complications. Although the course was once mandatory before prescribing combined mifepristone and misoprostol, the requirement has since been removed. The online community Canadian Abortion Providers Support (**https://www.caps-cpca.ubc.ca/index.php?title=Main_Page**) is backed by the SOGC and the College of Family Physicians of Canada and has downloadable resources such as patient handouts, checklists, and electronic medical record templates for primary care providers. An infographic published in early 2020 in *Canadian Family Physician* provides some basic information for both primary care providers and patients. Evidently, there is no shortage of resources to support the successful integration of medical abortion access into primary care practice (**https://www.cfp.ca/content/66/1/42/tab-figures-data**).[24]

Medical abortion is a core primary care service, yet patients' access to this service remains largely limited by the attitudes of many primary care providers. Conscientious objection and anti-choice attitudes among primary care physicians, refusal of clinic staff to clean clinic rooms in which medical abortion is provided, administrator reluctance to implement medical abortion protocol, and pharmacist refusal to dispense are some of the attitude barriers that increase the difficulty for patients to access medical abortion.[25] A culture shift within primary care regarding the provision of medical abortion is needed to realize the enormous potential that the mifepristone and misoprostol regimen has for reproductive health care, including in addressing geographic disparities of abortion services in Canada. Its discreet form, nearly universal Medicare coverage, and prescription accessibility via telemedicine allow it to surmount many of the barriers created by the COVID-19 pandemic. In this environment, family physicians have a duty to protect access to reproductive health care, and that means recognizing the importance of the abortion pill.

Dr Cohen is a family physician practising in Brighton, Ont.

Competing interests
None declared

References

1. Kappler M. Abortion is an essential service, but the pandemic is making it harder to access. *Huffington Post* 2020 Apr 9. Available from: **https://www.huffingtonpost.ca/entry/abortion-access-coronavirus_ca_5e8b54d5c5b6e7d76c6805c7**. Accessed 2021 Mar 10.
2. Osman L. Advocates sound alarm over COVID-19 limiting access to contraceptives, abortion. *Globe and Mail* 2020 Apr 2. Available from: **https://www.theglobeandmail.com/canada/article-advocates-sound-alarm-over-covid-19-limiting-access-to-contraceptives/**. Accessed 2021 Mar 10.
3. Dineley B, Munro S, Norman WV. Leadership for success in transforming medical abortion policy in Canada. *PloS One* 2020;15(1):e0227216.
4. Dunn S, Brooks M. Mifepristone. *CMAJ* 2018;190(22):E688.
5. Weeks C. Abortion-pill obstacles: how doctors' reluctance and long-distance travel stop many Canadians from getting Mifegymiso. *Globe and Mail* 2021 Mar 16. Available from: **https://www.theglobeandmail.com/canada/article-abortion-pill-obstacles-how-doctors-reluctance-and-long-distance/**. Accessed 2021 Mar 16.
6. Canadian Pharmacists Association. *COVID-19 and the responsible allocation of medications to patients* [press release 2020 Mar 17]. Ottawa, ON: Canadian Pharmacists Association; 2020. Available from: **https://www.pharmacists.ca/news-events/news/covid-19-and-the-responsible-allocation-of-medications-to-patients/**. Accessed 2021 Mar 10.
7. Miller A. Canada faces shortage of heartburn drug Pepcid after Zantac recall. *CBC News* 2020 Jan 15. Available from: **https://www.cbc.ca/news/health/pepcid-shortage-canada-zantac-recall-1.5426862**. Accessed 2021 Mar 12.
8. Lee L. COVID-19: world's biggest condom producer warns of global shortage. *Global News* 2020 Mar 27. Available from: **https://globalnews.ca/news/6743979/condom-shortage-coronavirus/**. Accessed 2021 Mar 10.
9. Ontario Coalition of Rape Crisis Centres. *COVID-19, pandemics and gender: OCRCC statement* [press release 2020 Apr 15]. Toronto, ON: Ontario Coalition of Rape Crisis Centres; 2020. Available from: **https://sexualassaultsupport.ca/covid-19-pandemics-and-gender-ocrcc-statement/#_ftn10**. Accessed 2021 Mar 10.
10. Stewart DE, Cecutti A. Physical abuse in pregnancy. *CMAJ* 1993;149(9):1257-63.
11. Burch RL, Gallup GG Jr. Pregnancy as a stimulus for domestic violence. *J Fam Violence* 2004;19(4):243-7.
12. Martin SL, Harris-Britt A, Li Y, Moracco KE, Kupper LL, Campbell JC. Changes in intimate partner violence during pregnancy. *J Fam Violence* 2004;19(4):201-10.
13. Abortion Rights Coalition of Canada [website]. *Abortion rights and healthcare during COVID-19.* Vancouver, BC: Abortion Rights Coalition of Canada; 2021. Available from: **https://www.arcc-cdac.ca/covid19.html**. Accessed 2021 Mar 10.
14. Jones RK, Witwer E, Jerman J. *Abortion incidence and service availability in the United States, 2017.* New York, NY: Guttmacher Institute; 2019. Available from: **https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017**. Accessed 2021 Mar 10.
15. National Abortion Federation Canada [website]. *Abortion coverage by region.* Vancouver, BC: National Abortion Federation Canada. Available from: **https://nafcanada.org/abortion-coverage-region/**. Accessed 2021 Mar 16.

16. Guilbert E, Costescu D, Wagner MS, Renner R, Norman WV, Dunn S, et al. *Canadian protocol for the provision of medical abortion via telemedicine.* Ottawa, ON: Society of Obstetricians and Gynaecologists of Canada; 2020. Available from: **https://www.sogc.org/common/Uploaded%20files/CANADIAN%20PROTOCOL%20FOR%20THE%20PROVISION%20OF%20MA%20VIA%20TELEMEDICINE.pdf**. Accessed 2021 Mar 10.
17. Endler M, Lavelanet A, Cleeve A, Ganatra B, Gomperts R, Gemzell-Danielsson K. Telemedicine for medical abortion: a systematic review. *BJOG* 2019;126(9):1094-102. Epub 2019 Apr 25.
18. Grossman D, Grindlay K, Buchacker T, Lane K, Blanchard K. Effectiveness and acceptability of medical abortion provided through telemedicine. *Obstet Gynecol* 2011;118(2 Pt 1):296-303.
19. Wiebe E, Campbell M, Ramasamy H, Kelly M. Comparing telemedicine to in-clinic medication abortions induced with mifepristone and misoprostol. *Contracept X* 2020;2:100023.
20. Grossman D, Grindlay K. Safety of medical abortion provided through telemedicine compared with in person. *Obstet Gynecol* 2017;130(4):778-82.
21. Norman WV. Induced abortion in Canada 1974–2005: trends over the first generation with legal access. *Contraception* 2012;85(2):185-91. Epub 2011 Aug 4.
22. Guilbert E, Wagner MS, Munro S, Wilcox ES, Dunn S, Soon JA, et al. Slow implementation of Mifepristone medical termination of pregnancy in Quebec, Canada: a qualitative investigation. *Eur J Contracept Reprod Health Care* 2020;25(3):190-8. Epub 2020 Apr 21.
23. Alam B, Kaler A, Mumtaz Z. Women's voices and medical abortions: a review of the literature. *Eur J Obstet Gynecol Reprod Biol* 2020;249:21-31. Epub 2020 Apr 8.
24. Bancsi A, Grindrod K. Update on medical abortion. *Can Fam Physician* 2020;66:42-4.
25. Weeks C. Abortion-pill inequality: how access varies widely across Canada. *Globe and Mail* 2018 Oct 12. Available from: **https://www.theglobeandmail.com/canada/article-abortion-pill-inequality-how-access-varies-widely-across-canada/**. Accessed 2021 Mar 16.

Can Fam Physician 2021;67:281-3. DOI: 10.46747/cfp.6704281