Pregnancy in a Time of Crisis

Since COVID-19 restrictions that have utterly recast how we live our lives were introduced, some glib speculation has asked whether we might expect a '*COVID babyboom*'. This has been couched in reports such as the sell-out of cheap pregnancy tests in discount retailers. Another angle on the speculation have been warm, fuzzy reports suggesting we are retreating into loving, domestic cocoons where greater intimacy and closeness prevail with the inevitable consequence of the happy announcement of a pending new arrival when we emerge.

COVID19 crisis responses have however generated conditions that may lead to increased unintended, unwanted or crisis pregnancies. Reports suggest diminishing contraceptive supplies, particularly of condoms. Access to the most effective methods of contraception in the form of long acting reversible contraception such as injections, intrauterine devices (IUDs) and implants requiring administration by a doctor has been suspended as part of measures to reduce face-to-face consultations in the interests of doctor and patient safety and to give priority to COVID related care.

Increased risk of domestic violence from abusive partners arising from confinement to home includes increased risk of rape leading to pregnancy. Higher incidence of domestic violence has also been reported during confinement meaning a relationship previously considered as loving and safe may have transpired to no longer be a relationship to want to bring a child into. Widespread job and income insecurity, concern about protections during maternity leave and uncertainty about the availability of childcare supports are conditions that mean a pregnancy, even one that may have begun as wanted, becomes a crisis.

In the context of our society where we set a high bar for the optimum conditions for raising a child, insecurity, anxiety and uncertain supports make contemplating parenthood much more challenging. All combined, the COVID-19 crisis has heightened the risk of a pregnancy being a crisis and glib comments about a possible COVID babyboom are highly insensitive to this.

In this light, continuity in the provision of reproductive health care including unplanned pregnancy supports and abortion care during COVID-19 is imperative. Abortion is highly time-sensitive and delays in provision mean ultimately it can be denied to those seeking access. Ability for abortion services to adapt their model of care to allow for remote provision is key to allowing continuity in access to time-sensitive abortion care.

Ireland is only providing abortion care since January 2019 under legislation allowing unrestricted access up to twelve weeks gestation and highly restrictive access after 12 weeks gestation. In designing the service, current evidence on the safety and efficacy of early medical abortions allowed for a model that integrated abortion care into pre-existing primary care (GPs and Women's Health Clinics) and secondary care (hospital) services. Women self-manage the medical abortion at home up to 10 weeks gestation. Between 10-12 weeks gestation they attend hospital and have the medication administered under medical supervision, usually as a day case. There is a mandatory three day wait and the service is supported by components delivered by telephone: an information helpline (myoptions.ie) gives details of providers and a 24 hour helpline staffed by nurses deals with medical related queries.

In response to COVID-19 measures, a revised model of care was announced on April 7th adapting (on a temporary basis) the service to allow for consultations to take place remotely by telephone. There were key enablers for moving to a remote model seamlessly. The pre-existing telephone helpline and nurse care line were already in place. During the first year of abortion care being available, self-managed early medical abortion accounted for the large majority of abortions provided. Evidence shows women's self-reported date of last menstruation is reliable to determine gestation accurately. Extensive materials on self-managing early medical abortion were already available in printed and electronic format that providers could draw on to support remote care.

For all of this, we still do not know how COVID-19 emergency has impacted on access to abortion for women in Ireland. Concerns that people have stayed away from health care to allow services prioritise responding to COVID or for fear of contracting the virus may extend to women not accessing abortion care. The remote model of care entails two lengthy phone consultations and having to leave home to collect the medication while women are advised that self-managing a medical abortion will involve some levels of cramping and bleeding.

Managing all of this while confined to home with all family members all of the time and subject to travel restrictions is difficult, especially if women have concerns about potential consequences of others knowing. Women are careful about who they talk to about having an abortion for fear of judgement, stigma and lack of understanding, even in post-Repeal Ireland. If a partner is abusive or controlling, suspecting or discovering their partner is terminating a pregnancy can escalate the risk to the woman.

Whether this remote model of care is any less satisfactory for women or indeed preferred by them, we do not yet know but research I am leading for the HSE Sexual Health and Crisis Pregnancy programme on women's experiences of using unplanned pregnancy and abortion services will collect data on the remote model to compare and contrast with data from face-to-face consultations.

If abortion access has been delayed by COVID19, then the 12-week timeframe for abortion provision in Ireland (other than in highly restrictive circumstances) means that some women will have been denied access. In this case, travelling for abortion care is the only remaining option.

Before COVID19, many women seeking abortion after receiving a diagnosis of foetal anomaly had to travel because criteria to qualify for abortion after 13 weeks requires clear evidence the anomaly is fatal within 28 days of birth. Even more than before, access to prenatal testing that would provide a diagnosis of foetal anomaly within the 12 week window was not available during COVID19.

Having to travel to access abortion care was a difficult enough journey before. Now under COVID19 travel restrictions, along with reduced level of surgical abortion services in England, the potential for denied abortion access is further increased.

The decision now by health services to resume non-COVID related care provision, using remote methods where possible, is very welcome in the hope that anyone who has been delaying seeking care will now consult their doctor. Administration of long-acting contraceptive care and early prenatal testing should be prioritised as essential face-to-face services as services are incrementally resumed. Retaining the remote model of care for abortion services while any level of self-isolation measures, restriction on travel and reduced childcare provision remain in place is important to optimise access.

And any tendency for glib remarks about a potential *COVID babyboom* should be tempered by reflection on how a pregnancy in a time of crisis is more likely to be a crisis pregnancy.

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