National Institute for Health and Care Excellence

Final

Abortion care

[I] Follow-up after medical abortion up to 10+0 weeks

NICE guideline NG140

Evidence reviews

September 2019

Final

These evidence reviews were developed by the National Guideline Alliance hosted by the Royal College of Obstetricians and Gynaecologists

Disclaimer

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Local commissioners and/or providers have a responsibility to enable the guideline to be applied when individual health professionals and their patients or service users wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with compliance with those duties.

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Contents

Follow-up after medical abortion up to 10^{+0} weeks

Review question

What is the best method of excluding an ongoing pregnancy after early (up to 10^{+0} weeks) medical abortion, when the expulsion has not been witnessed by healthcare professionals (for example, expulsion at home)?

Introduction

The aim of this review is to determine the best method of excluding ongoing pregnancy when the expulsion has not been witnessed by healthcare professionals.

At the time of development, the title of this guideline was 'Termination of pregnancy' and this term was used throughout the guideline. In response to comments from stakeholders, the title was changed to 'Abortion care' and abortion has been used throughout. Therefore, both terms appear in this evidence report.

Summary of the protocol

See Table 1 for a summary of the population, intervention, comparison and outcome (PICO) characteristics of this review.

Table 1: Summary of the protocol (PICO table)

Population	Women who have had a medical termination of pregnancy (up to 10^{+0} weeks of gestation) with mifepristone and misoprostol and expelled the pregnancy at home
Intervention	• In-person assessment with an ultrasound scan (not keeping women in to check the expulsion) • Remote assessment (e.g., consisting of low sensitivity urine pregnancy test, high sensitivity urine pregnancy test, multilevel urine pregnancy test, serum human chorionic gonadotropin (HCG), and/or self-assessment check lists)
Comparison	• In-person assessment versus remote assessment • Remote assessment protocol 1 versus remote assessment protocol 2
Outcome	**Critical outcomes:** • Missed ongoing pregnancy (failure to detect an ongoing pregnancy) • Correct implementation of follow-up strategy (comprehension; i.e., the women understand how to undertake the remote self-assessment protocol) • Patient satisfaction **Important outcomes:** • Adherence to follow-up strategy • Unscheduled visits or telephone calls to the termination service • Surgical intervention

HCG: human chorionic gonadotropin

For further details see the full review protocol in appendix A.

Clinical evidence

Included studies

Only studies conducted from 2000 onwards were considered for this review question, because after 2000 clinical practice changed to include the possibility of remote assessment for successful abortion of an early pregnancy when the expulsion has not been witnessed by healthcare professionals (for example, expulsion at home).

Six randomised controlled trials were included in this evidence review. Four of these studies compared routine clinic-based follow-up with remote, home-based, self-assessment follow-up after medical abortion (Bracken 2014; Ngoc 2014; Oppegaard 2015; Platais 2015) while the remaining 2 studies compared different methods of remote, home-based self-assessment follow-up (Blum 2016; Constant 2017).

The included studies are summarised in Table 2.

See the literature search strategy in appendix B and study selection flow chart in appendix C.

Excluded studies

Studies not included in this review with reasons for their exclusions are provided in appendix K.

Summary of clinical studies included in the evidence review

A summary of the studies that were included in this review are presented in Table 2.

Table 2: Summary of included studies

Study and setting	Population	Intervention/ comparison	Outcomes
Blum 2016 Randomised controlled trial Vietnam	n=600 Literate women seeking early medical abortion with gestational age ≤63 days	**Medical abortion:** 200mg mifepristone followed by 800micrograms (mcg) buccal misoprostol the next day. **Home-based follow-up:** Multilevel pregnancy test at 3, 7 and 14 days after mifepristone. **Home based follow up:** High sensitivity pregnancy test at 3, 7 and 14 days after mifepristone.	• Missed ongoing pregnancy • Patient satisfaction • Unscheduled visits to the abortion service • Surgical intervention
Bracken 2014 Randomised controlled trial England	n=999 Women aged 16 years or above requesting a medical abortion using mifepristone and misoprostol for a pregnancy ≤63	**Medical abortion:** 200mg oral mifepristone followed by 800mcg vaginal misoprostol 6-72 hours later in the clinic. **Routine clinical follow-up (Clinic):** In-clinic US and assessment of outcome of abortion 1 week later. Women in this group were also provided with a high-sensitivity urine	• Missed ongoing pregnancy • Patient satisfaction • Adherence to follow-up strategy • Unscheduled visits to the abortion service • Surgical intervention

Study and setting	Population	Intervention/ comparison	Outcomes
	days gestation by ultrasound scan	pregnancy test to take 3 weeks later and to phone the clinic with the results in case of being unable to attend their in-person visit. **Self-assessment (Remote):** Women choose between a telephone call, SMS text message or online questionnaire as their preferred method of remote follow-up, and they were given a low sensitivity pregnancy test to take 2 weeks later when they were also asked a series of questions about potential symptoms via their indicated method.	
Constant 2017 Randomised controlled trial South Africa	n=525 Women aged 18 years or above, requesting and clinically eligible for medical abortion using mifepristone with home-use of misoprostol of a pregnancy with a gestation up to 63 days.	**Medical abortion:** 200mg oral mifepristone followed by 800mcg buccal/sublingual misoprostol 24 to 48 hours later. **Home-based follow-up - Demonstration**: In-clinic practice of conducting and interpreting (5 min later) a low-sensitivity pregnancy test on own urine sample and interpreted the result at 5 minutes with guidance provided by a study fieldworker using a standardized procedure and pre-scripted instructions. Women then given a symptom checklist and a low sensitivity pregnancy test kit to use on first morning urine 14 days after mifepristone. **Home-based follow-up - Instruction**: Same pre-scripted verbal instructions were provided as for Demonstration group, but no practice demonstration. Women then given a symptom checklist and a low-sensitivity pregnancy test kit to use on first morning urine 14 days after mifepristone. Both group assessed in clinic 2 weeks later.	• Missed ongoing pregnancy • Patient satisfaction

Study and setting	Population	Intervention/ comparison	Outcomes
Ngoc 2014 Randomised controlled trial Vietnam	n=1433 Women requesting medical abortion of an intrauterine pregnancy up to 63 days gestation with a working personal phone and no known contraindications to abortion with mifepristone and/or misoprostol, who were able to complete an at-home symptom checklist	**Medical abortion:** "The most common treatment regimen used for early medical abortion services at the [4] hospitals consists of oral 200 mg mifepristone followed in 24–48 hours by 800micrograms buccal misoprostol administered at home." (p. 89) **Clinic follow-up (Clinic):** Clinic visit 2 weeks after mifepristone administration for a clinical assessment and transvaginal US to confirm the abortion outcome. **Remote follow-up (Remote):** A urine-based semi-quantitative pregnancy test, a urine sample cup, an information sheet explaining how to perform and interpret the test, and a questionnaire (which had the woman's baseline human chorionic gonadotropin (hCG) noted on it) to use at home before a scheduled phone-based follow-up appointment 2 weeks after mifepristone administration.	• Missed ongoing pregnancy • Patient satisfaction • Adherence to follow-up strategy • Unscheduled visits to the abortion service • Surgical intervention
Oppegaard 2015 Randomised controlled trial Austria, Finland, Norway and Sweden	n=929 Women aged 18 years or above requesting a medical abortion of a confirmed evolutive intrauterine pregnancy (visible intrauterine yolk sac or fetal heartbeat on US) of up to 63 days' gestation.	**Medical abortion:** 200mg mifepristone followed by 800mcg vaginal misoprostol 24 to 48 hours later at home. **Routine clinical follow-up (Clinic):** In-clinic assessment of outcome of abortion 1 to 3 weeks later by a low-sensitivity urine hCG test, measurement of hCG in serum, or ultrasonography. **Self-assessment (Remote):** Self-administration of a 2-step urine hCG DUO pregnancy test that has 2 detection thresholds of 5 and 1000IU/L, 1 to 3 weeks after the abortion to assess the outcome. Within 1 month of the initial consultation, the women underwent a telephone consultation with the clinic that aimed to ascertain if there had been expulsion of products of conception and whether the	• Missed ongoing pregnancy • Patient satisfaction • Unscheduled visits or telephone calls to the abortion service • Surgical intervention

Study and setting	Population	Intervention/ comparison	Outcomes
		hCG test was negative for either the 1000IU/L or 5IU/L concentrations.	
Platais 2015 Randomised controlled trial Moldova and Uzbekistan	n=2400 Women requesting medical abortion of pregnancies ≤63 days' gestation with no known contraindications to mifepristone and/or misoprostol.	**Medical abortion:** 200mg oral mifepristone followed by 400mcg sublingual misoprostol 24 to 48 hours later. **Clinic follow-up (Clinic):** Clinic-based follow-up 2 weeks after mifepristone administration assessing the abortion outcome by clinical examination, women's report of symptoms, and ultrasound, if needed. **Remote follow-up (Remote):** A semi-quantitative pregnancy test and a symptom checklist questionnaire to use at home before a scheduled phone-based follow-up appointment 2 weeks after mifepristone administration.	• Patient satisfaction • Adherence to follow-up strategy • Unscheduled visits to the abortion service • Surgical intervention

hCG: human chorionic gonadotrophin; mcg: micrograms; US: ultrasound

See the full evidence tables in appendix D and the forest plots in appendix E.

Quality assessment of clinical studies included in the evidence review

See the clinical evidence profiles in appendix F.

Economic evidence

Included studies

A systematic review of the economic literature was conducted but no economic studies were identified which were applicable to this review question.

A single economic search was undertaken for all topics included in the scope of this guideline. Please see supplementary material 2 for details.

Excluded studies

No full-text copies of articles were requested for this review and so there is no excluded studies list.

Economic model

No economic modelling was undertaken for this review because the committee agreed that other topics were higher priorities for economic evaluation.

Resource impact

Table 3: Unit costs of pregnancy tests considered

Resource	Unit costs	Source
High Sensitivity pregnancy Test Kit[1]	£0.74	NHS Supply Chain 2017
Low Sensitivity Pregnancy Test Kit[2]	£2.19	NHS Supply Chain 2017
Nurses Time (5 minutes)[2]	£3.08	PSSRU 2018

1 Mean cost of all reported high sensitivity pregnancy tests
2 Mean cost of all reported low sensitivity pregnancy tests
3 Band 5 Nurse excluding qualification costs

Evidence statements

Comparison 1. Remote follow-up versus clinic follow-up

Critical outcomes

Missed ongoing pregnancy (failure to detect an ongoing pregnancy)

RCT evidence (n=2935) did not detect a clinically important difference in 'the rate of missed ongoing pregnancy' between the remote follow-up group and the clinic-based follow-up group (3 RCTs, n=2935; RR= 4.91; 95% CI 0.58, 41.54; very low quality); however, there was uncertainty around this estimate.

Correct implementation of follow-up strategy (comprehension; i.e., the women understand how to undertake the remote self-assessment protocol)

No evidence was identified to inform this outcome.

Patient satisfaction (prefer remote follow-up for managing abortion follow-up in future)

RCT evidence that could not be meta-analysed due to high heterogeneity (I^2=99%; 4 RCTs, n=5060; very low quality) showed a higher clinically important difference in the rates of women who preferred remote follow-up for managing abortion in the future in the women who received remote follow-up compared to the women who received clinic-based follow-up in 3 of the 4 studies (RR=1.4, 95% CI 1.26, 1.55; RR=1.58; 95% CI 1.48, 1.69; and RR=2.22; 95% CI 2.01, 2.45, respectively) whereas there was no clinically important difference in the 4th study (RR=1.03; 95% CI 0.96, 1.1).

Important outcomes

Adherence to follow-up strategy

RCT evidence that could not be meta-analysed due to high heterogeneity (I^2=93%; 3 RCTs, n=4766; very low quality) showed no clinically important difference in 'the rates of adherence to the follow-up strategy' between women who received remote or clinic-based follow-up (RR=0.95, 95% CI 0.87, 1.03; RR=0.99; 95% CI 0.98, 1.01; and RR=1.07; 95% CI 1.05, 1.1, respectively).

Unscheduled visits to the abortion service

RCT evidence did not detect a clinically important difference in 'the rate of unscheduled visits to the abortion service' between the remote follow-up group and

the clinic-based follow-up group (4 RCTs, n=5454; RR= 1.2; 95% CI 0.91, 1.59; low quality); however, there was uncertainty around this estimate.

Unscheduled phone calls to the abortion service

RCT evidence did not detect a clinically important difference in 'the rate of unscheduled telephone calls to the abortion service' between the remote follow-up group and the clinic-based follow-up group (1 RCT, n=694; RR= 1.05; 95% CI 0.78, 1.43; very low quality); however, there was uncertainty around this estimate.

Surgical intervention

RCT evidence did not detect a clinically important difference in 'the rate of surgical intervention' between the remote follow-up group and the clinic-based follow-up group (4 RCTs, n=5703; RR= 0.93; 95% CI 0.7, 1.23; very low quality); however, there was uncertainty around this estimate.

Comparison 2. Remote follow-up 'Multi-level pregnancy test' versus remote follow-up 'High sensitivity pregnancy test'

Critical outcomes

Missed ongoing pregnancy (failure to detect an ongoing pregnancy)

RCT evidence reported no events of missed ongoing pregnancy in either the multi-level pregnancy test group or the high sensitivity pregnancy test group; therefore difference between groups could not be estimate (1 RCT, n=584; low quality).

Correct implementation of follow-up strategy (comprehension; i.e., the women understand how to undertake the remote self-assessment protocol)

No evidence was identified to inform this outcome.

Patient satisfaction (prefer remote follow-up for managing abortion follow-up in future)

RCT evidence showed no clinically important difference in 'the rate of women who preferred remote follow-up for managing abortion in the future' between the multi-level pregnancy test group and the high sensitivity pregnancy test group (1 RCT, n=584; RR=0.97; 95% CI 0.92, 1.03; moderate quality).

Important outcomes

Adherence to follow-up strategy

No evidence was identified to inform this outcome.

Unscheduled visits to the abortion service

RCT evidence showed a lower clinically important difference in 'the rate of unscheduled visits to the abortion service' in the multi-level pregnancy test group compared with the high sensitivity pregnancy test group (1 RCT, n=584; RR= 0.09; 95% CI 0.04, 0.22; moderate quality).

Unscheduled phone calls to the abortion service

No evidence was identified to inform this outcome.

Surgical intervention

RCT evidence did not detect a clinically important difference in 'the rate of surgical intervention' between the multi-level pregnancy test group and the high sensitivity pregnancy test group (1 RCT, n=584; RR= 0.33; 95% CI 0.01, 8.09; very low quality); however, there was uncertainty around this estimate.

Comparison 3. Remote follow-up 'Demonstration' versus remote follow-up 'Instruction'

Critical outcomes

Missed ongoing pregnancy (failure to detect an ongoing pregnancy)

RCT evidence did not detect a clinically important difference in 'the rate of missed ongoing pregnancy' between the Demonstration group and the Instruction group (1 RCT, n=426; RR=2.86; 95% CI 0.12, 69.89; very low quality); however, there was uncertainty around this estimate.

Correct implementation of follow-up strategy (comprehension; i.e., the women understand how to undertake the remote self-assessment protocol)

No evidence was identified to inform this outcome.

Patient satisfaction (prefer remote follow-up for managing abortion follow-up in future)

RCT evidence showed no clinically important difference in 'the rate of women who preferred remote follow-up for managing abortion in the future' between the Demonstration group and the Instruction group (1 RCT, n=458; RR=1; 95% CI 0.98, 1.03; moderate quality).

Important outcomes

Adherence to follow-up strategy

No evidence was identified to inform this outcome.

Unscheduled visits to the abortion service

No evidence was identified to inform this outcome.

Unscheduled phone calls to the abortion service

No evidence was identified to inform this outcome.

Surgical intervention

No evidence was identified to inform this outcome.

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter most

Verification of the success of an early medical abortion usually involves a follow-up in-person ultrasound scan. However, women could assess the success of the

procedure remotely themselves by following a remote assessment protocol including a urine pregnancy test, provided the remote protocol is as effective and safe as in-person assessment. Missed on-going pregnancy, correct implementation of follow-up strategy and patient satisfaction were therefore selected as critical outcomes. Adherence to follow-up strategy, unscheduled visits or telephone calls to the abortion service and surgical intervention were included as important outcomes due to the impact that needing an unscheduled or second appointment will have on both the woman and on available resources.

The quality of the evidence

The evidence in the pairwise comparisons was assessed using the GRADE methodology. The quality of the evidence across all outcomes ranged from very low to moderate quality and was most often downgraded due to imprecision, inconsistency or design limitations, e.g., 5 of the 6 studies were unblinded.

Benefits and harms

The evidence showed that there were no clinically important differences in the rate of adherence to follow-up strategy between the remote and clinic-based follow-up groups, and that is was unclear whether or not there were clinically important differences between these groups in the rates of missed ongoing pregnancy, unscheduled phone calls or visits to the abortion service or surgical intervention. The evidence also showed that in 3 of the 4 studies the women in the remote follow up groups expressed a clinically important higher rate of preference for remote follow up in a potential future abortion than in the clinic-based groups. When comparing different remote follow-up strategies, the evidence showed that there were no clinically important differences between these comparisons in terms of patient preference, but for both comparisons it was unclear whether or not there was a clinically important difference in the rates of missed ongoing pregnancy, and this was also the case for rates of surgical intervention for the multi-level urine pregnancy test versus a high sensitivity urine pregnancy test comparison. There was, however, a higher clinically important difference in the rate of unscheduled visits to the abortion service in the high-sensitivity urine pregnancy group compared to the multi-level urine pregnancy test group.

The committee noted that both in the evidence and in their experience many women do not return to clinic for their follow-up appointment. A potential benefit of these recommendations is therefore that by giving women both the choice of follow-up method and, in the case of self-assessment and remote follow-up, a pregnancy test, overall more women will receive follow-up. This in turn will help ensure that any unsuccessful medical abortions will have a higher chance of being identified earlier. Moreover, the committee noted that women have to wait longer after the abortion procedure in order to be able to use high sensitivity pregnancy tests because these are not reliable as soon after the abortion as other pregnancy tests. This means that the recommendations will also serve to ensure a quicker resolution of the whole medical abortion intervention. Overall, the committee therefore agreed that the recommendations serve to make abortion services more women-centred by focusing on women's preference for follow-up method and swift resolution in terms of the assessment of the outcome of the abortion.

As there was sufficient evidence to inform the recommendations, the committee decided to prioritise other areas addressed by the guideline for future research and therefore made no research recommendations regarding the best method of excluding an ongoing pregnancy after early (up to and including 10^{+0} weeks) medical

abortion, when the expulsion has not been witnessed by healthcare professionals (for example, expulsion at home).

Cost effectiveness and resource use

A systematic review of the economic literature was conducted but no relevant studies were identified which were applicable to this review question.

The committee considered that there was unlikely to be a significant resource impact from the recommendations made. Any net effect was likely to be cost saving due to fewer clinic visits and fewer ultrasound scans being required for women opting for self-assessment or remote follow-up rather than in-clinic follow-up. Moreover, although low sensitive pregnancy tests are more expensive than high sensitivity pregnancy tests, this difference in price will be offset by fewer clinic visits (and fewer false positive test results) by women who receive the low sensitivity pregnancy test compared to the high sensitivity pregnancy test.

References

Blum 2016

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Constant, D., Harries, J., Daskilewicz, K., Myer, L., Gemzell-Danielsson, K., Is self-assessment of medical abortion using a low-sensitivity pregnancy test combined with a checklist and phone text messages feasible in South African primary healthcare settings? A randomized trial, PLoS ONE, 12 (6) (no pagination), 2017

Ngoc 2014

Ngoc, N. T. N., Bracken, H., Blum, J., Nga, N. T. B., Minh, N. H., Van Nhang, N., Lynd, K., Winikoff, B., Blumenthal, P. D., Acceptability and feasibility of phone follow-up after early medical abortion in Vietnam: A randomized controlled trial, Obstetrics and gynecology, 123, 88-95, 2014

Oppegaard 2015

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Platais 2015

Platais, I., Tsereteli, T., Comendant, R., Kurbanbekova, D., Winikoff, B., Acceptability and feasibility of phone follow-up with a semiquantitative urine pregnancy test after medical abortion in Moldova and Uzbekistan, Contraception, 91, 178-183, 2015

Appendices

Appendix A – Review protocols

Review protocol for review question: What is the best method of excluding an ongoing pregnancy after early (up to 10^{+0} weeks) medical abortion, when the expulsion has not been witnessed by healthcare professionals (for example, expulsion at home)?

Field (based on PRISMA-P	Content
Review question in SCOPE	What is the best method of excluding an ongoing pregnancy after early (up to 10 weeks) medical termination of pregnancy, when the expulsion has not been witnessed by healthcare professionals (for example, expulsion at home)?
Review question in guideline	What is the best method of excluding an ongoing pregnancy after early (up to 10^{+0} weeks) medical termination of pregnancy, when the expulsion has not been witnessed by healthcare professionals (for example, expulsion at home)?
Type of review question	Intervention
Objective of the review	To determine the best method of excluding ongoing pregnancy when the expulsion has not been witnessed by healthcare professionals.
Eligibility criteria – population	Women who have had a medical termination of pregnancy (up to 10^{+0} weeks of gestation) with mifepristone and misoprostol and expelled the pregnancy at home Exclusions: - No studies with indirect populations
Eligibility criteria – intervention(s)	• In-person assessment with an ultrasound scan (not keeping in women to check the expulsion) • 2. Remote assessment (e.g., consisting of low sensitivity urine pregnancy test, high sensitivity urine pregnancy test, multilevel urine pregnancy test, serum human chorionic gonadotropin (HCG), and/or self-assessment check lists)
Eligibility criteria – comparator(s)	The following comparisons will be considered: 1. In-person assessment versus remote assessment 2. Remote assessment protocol 1 versus remote assessment protocol 2
Outcomes and prioritisation	**Critical outcomes:** • Missed ongoing pregnancy (failure to detect an ongoing pregnancy) • Correct implementation of follow-up strategy (comprehension; i.e., the women understand how to undertake the remote self-assessment protocol) • Patient satisfaction **Important outcomes:** • Adherence to follow-up strategy

Field (based on PRISMA-P	Content
	• Unscheduled visits or telephone calls to the termination service • Surgical intervention
Eligibility criteria – study design	- Systematic reviews of RCTs - RCTs
Other inclusion exclusion criteria	Inclusion: - English-language
Proposed sensitivity/sub-group analysis, or meta-regression	Stratified analyses based on the following sub-groups of women, where possible: Medical conditions: - Complex pre-existing medical conditions - No complex pre-existing medical conditions English speaking versus non-English speaking Age <18 or ≥18 years
Selection process – duplicate screening/selection/analysis	Dual sifting will be undertaken for this question using NGA STAR software, with resolution of discrepancies in discussion with the senior reviewer if necessary. Sifting, data extraction, appraisal of methodological quality and GRADE assessment will be performed by the systematic reviewer. Quality control will be performed by the senior systematic reviewer. Dual data extraction will not be performed for this question.
Data management (software)	Pairwise meta-analyses of RCT data will be performed using Cochrane Review Manager (RevMan5). 'GRADEpro' will be used to assess the quality of evidence for each outcome. NGA STAR software will be used for study sifting, data extraction, recording quality assessment using checklists and generating bibliographies/citations,
Information sources – databases and dates	Sources to be searched: Medline, Medline In-Process, CCTR, CDSR, DARE, HTA, Embase Limits (e.g. date, study design): Apply standard animal/non-English language exclusion Dates: 2000 onwards A date limit of 2000 will be applied because after 2000 clinical practice changed to include the possibility of remote assessment for successful termination of an early pregnancy when the expulsion has not been witnessed by healthcare professionals (for example, expulsion at home)?
Identify if an update	Not an update
Author contacts	For details please see the guideline in development web site
Highlight if amendment to previous protocol	For details please see section 4.5 of Developing NICE guidelines: the manual
Search strategy – for one database	For details please see appendix B

Field (based on PRISMA-P	Content
Data collection process – forms/duplicate	A standardised evidence table format will be used, and published as appendix D (clinical evidence tables) or H (economic evidence tables)
Data items – define all variables to be collected	For details please see evidence tables in appendix D (clinical evidence tables) or H (economic evidence tables)
Methods for assessing bias at outcome/study level	Standard study checklists will be used to critically appraise individual studies. For details please see section 6.2 of Developing NICE guidelines: the manual Appraisal of methodological quality: The methodological quality of each study will be assessed using an appropriate checklist: • Cochrane risk of bias tool for RCTs The risk of bias across all available evidence will be evaluated for each outcome using an adaptation of the 'Grading of Recommendations Assessment, Development and Evaluation (GRADE) toolbox' developed by the international GRADE working group http://www.gradeworkinggroup.org/
Criteria for quantitative synthesis (where suitable)	For details please see section 6.4 of Developing NICE guidelines: the manual
Methods for analysis – combining studies and exploring (in)consistency	Synthesis of data: Pairwise meta-analysis will be conducted where appropriate for all outcomes. When meta-analysing continuous data, change scores will be pooled in preference to final scores. For details regarding inconsistency, please see the methods chapter Minimally important differences: Default values will be used of: 0.8 and 1.25 for dichotomous outcomes (relative risks); 0.5 times SD (of control group) for continuous outcomes.
Meta-bias assessment – publication bias, selective reporting bias	For details please see section 6.2 of Developing NICE guidelines: the manual. If sufficient relevant RCT evidence is available, publication bias will be explored using RevMan software to examine funnel plots.
Assessment of confidence in cumulative evidence	For details please see sections 6.4 and 9.1 of Developing NICE guidelines: the manual
Rationale/context – Current management	For details please see the introduction to the evidence review
Describe contributions of authors and guarantor	A multidisciplinary committee developed the guideline. The committee was convened by The National Guideline Alliance and chaired by Profession Iain Cameron in line with section 3 of Developing NICE guidelines: the manual. Staff from The National Guideline Alliance will undertake systematic literature searches, appraise the evidence, conduct meta-analysis and cost-effectiveness analysis where appropriate, and draft the guideline in collaboration with the committee. For details please see the methods chapter

Field (based on PRISMA-P	Content
Sources of funding/support	The National Guideline Alliance is funded by NICE and hosted by the Royal College of Obstetricians and Gynaecologists
Name of sponsor	The National Guideline Alliance is funded by NICE and hosted by the Royal College of Obstetricians and Gynaecologists
Roles of sponsor	NICE funds The National Guideline Alliance to develop guidelines for those working in the NHS, public health, and social care in England
PROSPERO registration number	Not registered

GRADE: Grading of Recommendations Assessment, Development and Evaluation; HCG: human chorionic gonadotropin; NHS: National Health Service; NICE: National Institute for Health and Care Excellence; NGA: National Guideline Alliance; RCT: randomised controlled trial; SD: standard deviation;

Appendix B – Literature search strategies

Literature search strategy for review question: What is the best method of excluding an ongoing pregnancy after early (up to 10^{+0} weeks) medical abortion, when the expulsion has not been witnessed by healthcare professionals (for example, expulsion at home)?

The search for this topic was last run on 19th November 2018 during the re-runs for this guideline.

Database: Medline & Embase (Multifile)
Last searched on **Embase Classic+Embase** 1947 to 2018 November 16, **Ovid MEDLINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R)** 1946 to November 16, 2018
Date of last search: 19th November 2018

#	Searches
1	exp abortion/ use emczd
2	exp pregnancy termination/ use emczd
3	exp Abortion, Induced/ use ppez
4	Abortion Applicants/ use ppez
5	exp Abortion, Spontaneous/ use ppez
6	exp Abortion, Criminal/ use ppez
7	Aborted fetus/ use ppez
8	fetus death/ use emczd
9	abortion.mp.
10	(abort$ or postabort$ or preabort$).tw.
11	((f?etal$ or f?etus$ or gestat$ or midtrimester$ or pregnan$ or prenatal$ or pre natal$ or trimester$) and terminat$).tw.
12	((f?etal$ or f?etus$) adj loss$).tw.
13	((gestat$ or midtrimester$ or pregnan$ or prenatal$ or pre natal$ or trimester$) adj3 loss$).tw.
14	(((elective$ or threaten$ or voluntar$) adj3 interrupt$) and pregnan$).tw.
15	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14
16	exp Pregnancy Tests/ use ppez
17	exp pregnancy test/ use emczd
18	((pregnan$ or LSPT or MSPT or HSPT or MLPT or HLPT or LSUP or MSUP or HSUP) adj test$).tw.
19	Self-Assessment/ use ppez
20	self evaluation/ use emczd
21	*Self Report/ use ppez
22	*self report/ use emczd
23	Checklist/ use ppez
24	checklist/ use emczd
25	((self-assess$ or selfassess$ or self assess$ or self-evaluat$ or selfevaluat$ or self evaluat$) adj3 (success or outcome$ or complet$ or home or remote)).tw.
26	checklist$.tw.
27	exp Chorionic Gonadotropin/ use ppez

#	Searches
28	chorionic gonadotropin/ use emczd
29	((beta-hcg$ or hcg$) adj (test$ or level$ or measurement$)).tw.
30	exp Telemedicine/ use ppez
31	exp telemedicine/ use emczd
32	(telemed$ or teleconsult$).tw.
33	Self Administration/ use ppez
34	drug self administration/ use emczd
35	(exp home/ or home care/) use emczd
36	home monitoring/ use emczd
37	follow up/ use emczd
38	((follow-up or followup or follow up) adj (care or model$ or procedure$)).tw.
39	((simple$ or standard$ or traditional$ or mToP) adj (follow-up or followup or follow up)).tw.
40	((in-person$ or in-clinic$ or in-office$ or remote$ or telephone$ or ultrasound$ or ultrasonograph$ or sonogra$ or endosonogra$) adj3 (follow-up or followup or follow up or assess$)).tw.
41	16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40
42	15 and 41
43	(controlled clinical trial or pragmatic clinical trial or randomized controlled trial).pt. or drug therapy.fs. or (groups or placebo or randomi#ed or randomly or trial).ab.
44	crossover procedure/ or double blind procedure/ or randomized controlled trial/ or single blind procedure/ or (assign* or allocat* or crossover* or cross over* or ((doubl* or singl*) adj blind*) or factorial* or placebo* or random* or volunteer*).ti,ab.
45	meta-analysis/
46	meta-analysis as topic/
47	systematic review/
48	meta-analysis/
49	(meta analy* or metanaly* or metaanaly*).ti,ab.
50	((systematic or evidence) adj2 (review* or overview*)).ti,ab.
51	((systematic* or evidence*) adj2 (review* or overview*)).ti,ab.
52	(reference list* or bibliograph* or hand search* or manual search* or relevant journals).ab.
53	(search strategy or search criteria or systematic search or study selection or data extraction).ab.
54	(search* adj4 literature).ab.
55	(medline or pubmed or cochrane or embase or psychlit or psyclit or psychinfo or psycinfo or cinahl or science citation index or bids or cancerlit).ab.
56	cochrane.jw.
57	((pool* or combined) adj2 (data or trials or studies or results)).ab.
58	letter/
59	editorial/
60	news/
61	exp historical article/
62	Anecdotes as Topic/
63	comment/
64	case report/

#	Searches
65	(letter or comment*).ti.
66	58 or 59 or 60 or 61 or 62 or 63 or 64 or 65
67	randomized controlled trial/ or random*.ti,ab.
68	66 not 67
69	animals/ not humans/
70	exp Animals, Laboratory/
71	exp Animal Experimentation/
72	exp Models, Animal/
73	exp Rodentia/
74	(rat or rats or mouse or mice).ti.
75	68 or 69 or 70 or 71 or 72 or 73 or 74
76	letter.pt. or letter/
77	note.pt.
78	editorial.pt.
79	case report/ or case study/
80	(letter or comment*).ti.
81	76 or 77 or 78 or 79 or 80
82	randomized controlled trial/ or random*.ti,ab.
83	81 not 82
84	animal/ not human/
85	nonhuman/
86	exp Animal Experiment/
87	exp Experimental Animal/
88	animal model/
89	exp Rodent/
90	(rat or rats or mouse or mice).ti.
91	83 or 84 or 85 or 86 or 87 or 88 or 89 or 90
92	75 use ppez
93	91 use emczd
94	92 or 93
95	43 use ppez
96	44 use emczd
97	95 or 96
98	(or/45-46,49,51-56) use ppez
99	(or/47-50,52-57) use emczd
100	98 or 99
101	42 and 94
102	42 not 101
103	97 or 100
104	102 and 103
105	limit 104 to english language
106	limit 105 to yr="2000 -Current"
107	remove duplicates from 106

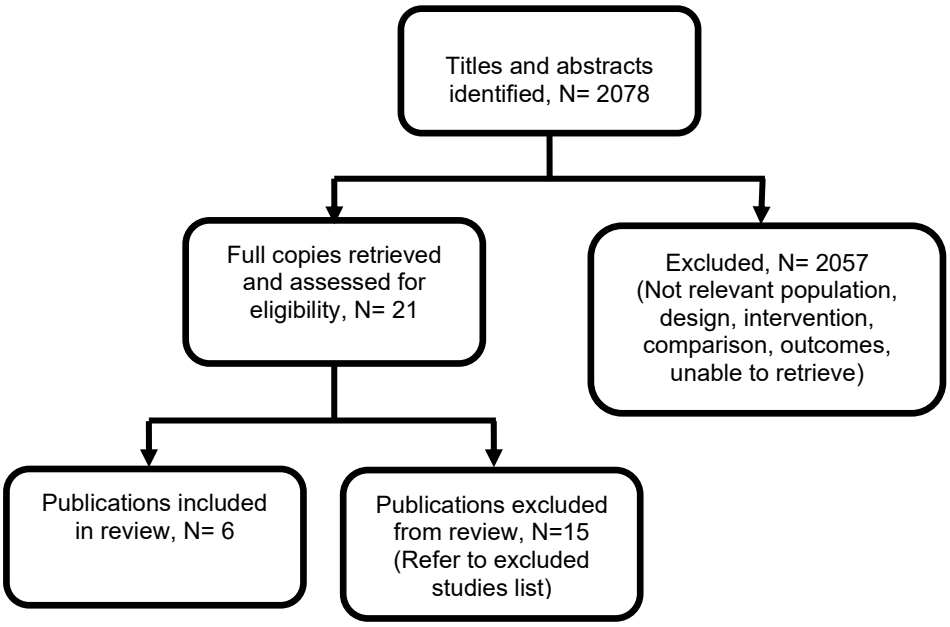
Database: Cochrane Library via Wiley Online
Date of last search: 19th November 2018

#	Searches
#1	MeSH descriptor: [Abortion, Induced] explode all trees
#2	MeSH descriptor: [Abortion Applicants] explode all trees
#3	MeSH descriptor: [Abortion, Spontaneous] explode all trees
#4	MeSH descriptor: [Abortion, Criminal] explode all trees
#5	MeSH descriptor: [Aborted Fetus] explode all trees
#6	"abortion":ti,ab,kw (Word variations have been searched)
#7	(abort* or postabort* or preabort*):ti,ab,kw (Word variations have been searched)
#8	((fetal* or fetus* or foetal* or foetus* or gestat* or midtrimester* or pregnan* or prenatal* or pre natal* or trimester*) and terminat*):ti,ab,kw (Word variations have been searched)
#9	((fetal* or fetus* or foetal* or foetus*) next loss*):ti,ab,kw (Word variations have been searched)
#10	((gestat* or midtrimester* or pregnan* or prenatal* or pre natal* or trimester*) near/3 loss*):ti,ab,kw (Word variations have been searched)
#11	(((elective* or threaten* or voluntar*) near/3 interrupt*) and pregnan*):ti,ab,kw (Word variations have been searched)
#12	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11
#13	MeSH descriptor: [Pregnancy Tests] explode all trees
#14	((pregnan* or LSPT or MSPT or HSPT or MLPT or HLPT or LSUP or MSUP or HSUP) next test*):ti,ab,kw (Word variations have been searched)
#15	MeSH descriptor: [Self-Assessment] this term only
#16	MeSH descriptor: [Self Report] this term only
#17	MeSH descriptor: [Checklist] this term only
#18	((self-assess* or selfassess* or self assess* or self-evaluat* or selfevaluat* or self evaluat*) near/3 (success or outcome* or complet* or home or remote)):ti,ab,kw (Word variations have been searched)
#19	checklist*:ti,ab,kw (Word variations have been searched)
#20	MeSH descriptor: [Chorionic Gonadotropin] explode all trees
#21	((beta-hcg* or hcg*) next (test* or level* or measurement*)):ti,ab,kw (Word variations have been searched)
#22	MeSH descriptor: [Telemedicine] explode all trees
#23	(telemed* or teleconsult*):ti,ab,kw (Word variations have been searched)
#24	MeSH descriptor: [Self Administration] this term only
#25	((follow-up or followup or follow up) next (care or model* or procedure*)):ti,ab,kw (Word variations have been searched)
#26	((simple* or standard* or traditional* or mToP) next (follow-up or followup or follow up)):ti,ab,kw (Word variations have been searched)
#27	((in-person* or in-clinic* or in-office* or remote* or telephone* or ultrasound* or ultrasonograph* or sonogra* or endosonogra*) near/3 (follow-up or followup or follow up or assess*)):ti,ab,kw (Word variations have been searched)
#28	#13 or #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23 or #24 or #25 or #26 or #27
#29	#12 and #28

Appendix C – Clinical evidence study selection

Clinical evidence study selection for review question: What is the best method of excluding an ongoing pregnancy after early (up to 10^{+0} weeks) medical abortion, when the expulsion has not been witnessed by healthcare professionals (for example, expulsion at home)?

Figure 1: Study selection flow chart



Appendix D – Clinical evidence tables

Clinical evidence tables for review question: What is the best method of excluding an ongoing pregnancy after early (up to 10^{+0} weeks) medical abortion, when the expulsion has not been witnessed by healthcare professionals (for example, expulsion at home)?

Study details	Participants	Interventions	Outcomes and Results	Comments
Full citation Blum, J., Sheldon, W. R., Ngoc, N. T. N., Winikoff, B., Nga, N. T. B., Martin, R., Van Thanh, L., Blumenthal, P. D., Randomized trial assessing home use of two pregnancy tests for determining early medical abortion outcomes at 3, 7 and 14 days after mifepristone, Contraception, 94, 115-121, 2016 **Ref Id** 815794 **Country/ies where the study was carried out** Vietnam **Study type** Randomised controlled trial **Aim of the study**	**Sample size** n=600 randomised (300 to each follow-up group; 7 and 9 women, respectively, were lost to follow up in the MLPT and HSPT groups). **Characteristics** Multi-level pregnancy test (MLPT, n=300): Mean (SD; range) age: 30 (6; 17-45) years; parity 0/1/2/3+: n=77/89/116/18; mean gestational age (SD: range): 42 (5; 30-61) days; prior abortions: n =135. High sensitivity pregnancy test (HSPT, n=300): Mean (SD; range) age: 29 (6; 17-46) years; parity 0/1/2/3+: n=86/92/105/17; mean gestational age (SD: range): 42 (6; 30-63) days; prior abortions: n =117. **Inclusion criteria**	Women randomised into 2 groups of home-based follow-up: **Multilevel pregnancy test (MLPT);** **High sensitivity pregnancy test (HSPT).** **Medical abortion:** 200mg mifepristone followed by 800micrograms (mcg) buccal misoprostol the next day. The women in each group were given 3 pregnancy tests to take at home at 3, 7 and 14 days after mifepristone after it had been explained to them how to use and interpret the tests and after they had performed a baseline test at the clinic. The tests were also accompanied by written and pictorial test instructions. The women	**Outcome: Missed ongoing pregnancy (failure to detect an ongoing pregnancy)** MLPT: 0/293 HSPT 0/291 **Outcome: Patient satisfaction (preferred location for managing abortion follow-up in future)** MLPT: At clinic/at home with pregnancy test/no preference: 28/257/8 of a total of 293 women HSPT: At clinic/at home with pregnancy test/no preference: 25/263/3 of a total of 291 women **Outcome: Unscheduled visits to the abortion service** MLPT: 5/293 HSPT 56/291 **Outcome: Surgical intervention (for ruptured ectopic pregnancy)** MLPT: 0/293 HSPT 1/291	**Limitations** **Quality of study:** Risk of bias assessed using Cochrane Risk of Bias tool Random sequence generation: Low risk; not clearly detailed how the list was generated, but probably adequately. Allocation concealment: Low risk; sequentially numbered opaque envelopes, prepared by staff off-site. Blinding of participants and personnel: Unblinded; low risk to objective outcomes, high risk to subjective outcomes. Blinding of outcome assessment: Unblinded; low risk to objective outcomes, high risk to subjective outcomes. Attrition: Low risk, data from 293/300 (MLPT) and

Study details	Participants	Interventions	Outcomes and Results	Comments
"To evaluate the accuracy, feasibility and acceptability of two urine pregnancy tests in assessing abortion outcomes at three time points after mifepristone administration." (p. 115) **Study dates** June 2013 – February 2014 **Source of funding** Anonymous donor	Literate women seeking early medical abortion with gestational age ≤63 days who were willing to use up to 3 home pregnancy tests and to return to the clinic. **Exclusion criteria** None reported	were asked to record and interpret the results and abortion symptoms in a home diary. **Follow-up:** Two weeks after mifepristone unless • MLPT group: "Women in the MLPT group whose tests showed either a decrease or increase in hCG after using the test were instructed to return for clinic follow-up immediately. If hCG levels were unchanged, women were instructed to wait and administer the next scheduled pregnancy test." (p 116) • HSPT: "Women in the HSPT group with negative results (hCGb<25 mIU/mL) were instructed to return for clinic follow-up immediately." 9p. 116)		291/300 (HSPT) included for all outcomes. Selective reporting: Low risk, the main outcomes in the protocol are reported. **Other information** None
Full citation Bracken, H., Lohr, P. A., Taylor, J., Morroni, C., Winikoff, B., RU OK? The acceptability and feasibility of remote technologies for follow-up after early medical abortion,	**Sample size** n=999 randomised; 498 to remote follow-up and 501 to clinic follow-up; of these 11 and 10 were withdrawn from the remote and clinic follow-up groups, respectively (no reasons given).	**Routine clinical follow-up (Clinic):** In-clinic ultrasound and assessment of outcome of abortion 1 week later. Women in this group were also provided with a high-sensitivity urine pregnancy test to take 3 weeks later	**Outcome: Missed ongoing pregnancy (failure to detect an ongoing pregnancy)** Clinic: 0/337 Remote: 0/322 **Outcome: Patient satisfaction (not reported, but preferred**	**Limitations** **Quality of study:** Risk of bias assessed using Cochrane Risk of Bias tool

Study details	Participants	Interventions	Outcomes and Results	Comments
Contraception, 90, 29-35, 2014 **Ref Id** 831585 **Country/ies where the study was carried out** England **Study type** Randomised controlled trial **Aim of the study** "We tested the effectiveness and feasibility of remote communication technologies to increase follow-up after early medical abortion." (p. 29) **Study dates** April 2011 – February 2012 **Source of funding** Anonymous donor	**Characteristics** Clinic follow-up (Clinic, n=491): Mean (SD; range) age: 26.6 (7.1; 16-48) years; gestational age ≤42 / 43-49 / 50-56 / 57-63 days: n=122 / 172 / 129 / 68; prior medical abortions: n=97 Remote follow-up (Remote, n=487): Mean (SD; range) age: 26.5 (6.8; 16-44) years; gestational age ≤42 / 43-49 / 50-56 / 57-63 days: n=108 / 188 / 127 / 64; prior medical abortions: n=83 "Women in the remote group were significantly more educated (p=.004) and more likely to have a computer at home (p=.028) than those in the clinic-based group." (p. 31) **Inclusion criteria** Women aged 16 years or above requesting a medical abortion using mifepristone and misoprostol for a pregnancy ≤63 days gestation by ultrasound scan, who willing and able to communicate in English, and had access to a mobile	and to phone the clinic with the results in case of being unable to attend their in-person visit. A clinic appointment was given if the pregnancy test was positive or a women reported any concerning symptoms. **Self-assessment (Remote):** Women choose between a telephone call, SMS text message or online questionnaire as their preferred method of remote follow-up, and they were given a low sensitivity pregnancy test to take 2 weeks later when they were also asked the following questions via their indicated method: - “Did you experience no or only one day of heavy bleeding during treatment? - Do you have any of the following today: breast tenderness, nausea or morning sickness, frequent urination, or exhaustion or tiredness? - Thinking of how you feel at this moment, physically and emotionally,	**location for managing abortion follow-up in future is)** Clinic: At clinic/at home with telephone follow-up / at home with SMS text message follow-up / at home with online questionnaire follow-up / no preference: 51/239/55/0/10 of a total of 355 women Remote: At clinic/at home with telephone follow-up / at home with SMS text message follow-up / at home with online questionnaire follow-up / no preference: 23/134/119/24/26 of a total of 326 women **Outcome: Adherence to follow-up strategy (completed follow up)** Clinic: 337/464 (of these 337, 58 returned to the clinic and 279 were contacted by phone by clinic staff) Remote: 322/469 **Outcome: Unscheduled visit to the abortion service** Clinic: 27/464 Remote: 18/469 **Outcome: Surgical intervention (for ongoing pregnancy, retained products of conception or medically indicated)** Clinic: 14/491	Random sequence generation: Low risk; computer-generated. Allocation concealment: Low risk; sequentially numbered opaque envelopes, prepared by staff off-site, it seems. Blinding of participants and personnel: Unblinded; low risk to objective outcomes, high risk to subjective outcomes. Blinding of outcome assessment: Unblinded; low risk to objective outcomes, high risk to subjective outcomes. Attrition: Low risk for the important outcomes (data from at least 464/491 in the clinic group and 469/487 in the remote group) high risk for the critical outcomes (data from 337-355/491 in the clinic group and 322-326/487 in the remote group). Selective reporting: Unclear risk, very little detail on the main outcomes included in the protocol. **Other information** None

Study details	Participants	Interventions	Outcomes and Results	Comments
	phone, the internet or a telephone **Exclusion criteria** Not reported	would you say that you still feel pregnant? - Is your pregnancy test positive?" (p. 30) In cases where the answer to any of the questions was "yes," the woman was advised to schedule a clinic appointment. **Medical abortion:** 200mg oral mifepristone followed by 800 mcg vaginal misoprostol 6 to 72 hours later in the clinic. **Follow-up:** See details listed under "interventions". Three attempts were made to contact women who failed to return/call in (Clinic) or respond to advice to schedule a clinic appointment (Remote).	Remote: 8/487	
Full citation Constant, D., Harries, J., Daskilewicz, K., Myer, L., Gemzell-Danielsson, K., Is self-assessment of medical abortion using a low-sensitivity pregnancy test combined with a checklist and phone text messages feasible in South African primary	**Sample size** n=525 randomised (263 to Demonstration and 262 to Instruction; of these n=32 were lost to follow-up in Demonstration (1 withdrew, 26 did not return, and there were 5 protocol violations) and n=35 were lost to follow-up in Instruction (1 withdrew, 32 did not return,	Women randomised into 2 groups of home-based follow-up: **Demonstration:** In-clinic practice of conducting and interpreting (5 min later) a low-sensitivity pregnancy test on own urine sample and interpreted the result at	**Outcome: Missed ongoing pregnancy (failure to detect an ongoing pregnancy)** Demonstration: 1/218 Instruction: 0/208 **Outcome: Patient satisfaction (preferred location for managing abortion follow-up in future)**	**Limitations** **Quality of study:** Risk of bias assessed using Cochrane Risk of Bias tool Random sequence generation: Low risk; computer-generated. Allocation concealment: Low risk;

Study details	Participants	Interventions	Outcomes and Results	Comments
healthcare settings? A randomized trial, PLoS ONE, 12 (6) (no pagination), 2017 **Ref Id** 713699 **Country/ies where the study was carried out** South Africa **Study type** Randomised controlled trial **Aim of the study** "To evaluate feasibility of self-assessment of medical abortion outcome using a low-sensitivity urine pregnancy test, checklist and text messages. The study assessed whether accurate self-assessment required a demonstration of the low-sensitivity urine pregnancy test or if verbal instructions suffice." (p. 1) **Study dates** September 2014 – June 2015	and there were 2 protocol violations)) **Characteristics** Demonstration (n=263): Age 18-24 / 25-29 / 30 or above years: n=101/72/90; previous pregnancies 0/1/2+: n=52/100/111; gestational age 28-48 / 49-63 days: n=122 / 141; prior abortions: n=13; prior medical abortions: n=6 Instruction (n=262): Age 18-24 / 25-29 / 30 or above years: n=98/76/88; previous pregnancies 0/1/2+: n=42/96/124; gestational age 28-48 / 49-63 days: n=102 / 160; prior abortions: n=18; prior medical abortions: n=8. **Inclusion criteria** Women aged 18 years or above, requesting and being clinically eligible for medical abortion using mifepristone with home-use of misoprostol of a pregnancy with a gestation up to 63 days, who were willing to receive abortion-related text messages on their phone over the next 14	5 minutes with guidance provided by a study fieldworker using a standardized procedure and pre-scripted instructions. Women then given a symptom checklist and a low sensitivity pregnancy test kit to use on first morning urine 14 days after mifepristone. **Instruction:** Same pre-scripted verbal instructions were provided as for Demonstration group, but no practice demonstration. Women then given a symptom checklist and a low-sensitivity pregnancy test kit to use on first morning urine 14 days after mifepristone. Both groups received 19 timed, automated text messages to their mobile phones over the next 14 days including reminders on how to store the low sensitivity pregnancy test kit (i.e.,) "away from direct heat, taking their misoprostol, what abortion symptoms to expect, managing pain, responding to excessive bleeding and	Demonstration: At clinic/at home with pregnancy test with or without checklist and SMS, contact clinic if needed: 3/228 of a total of 231 women Instruction: At clinic/at home with pregnancy test with or without checklist and SMS, contact clinic if needed: 4/223 of a total of 227 women **Outcome: Unscheduled visits or telephone calls to the abortion service:** Not reported by group, authors just state that there were a total of 15/458 such visits/calls and that the groups did not differ in their frequency or reasons	sequentially numbered opaque envelopes, prepared by staff off-site. Blinding of participants and personnel: Clinic staff, but not field workers or participants blinded; low risk to objective outcomes, high risk to subjective outcomes. Blinding of outcome assessment: Clinic staff, but not field workers or participants blinded; low risk to objective outcomes, high risk to subjective outcomes. Attrition: High risk, data from 218-231/263 (Demonstration) and 208-227/262 (Instruction) for the included outcomes. Selective reporting: Unclear risk, very little detail on the main outcomes included in the protocol. **Other information** Non-inferiority study

Study details	Participants	Interventions	Outcomes and Results	Comments
Source of funding Safe Abortion Action Fund; University of Cape Town Research Office; The Harry Crossley Clinical Research Fellowship; The South African National Research Foundation; Exelgyn	days and able to give informed consent **Exclusion criteria** Not reported	other complications, conducting the pregnancy test and attending follow-up appointments" (p. 5) At in-clinic follow-up 2 weeks later (unclear whether this is at the same time as the women asked to perform the remote assessment or 2 weeks after misoprostol or 2 weeks later again) women "were also asked to interpret their checklist as showing that "their abortion was complete" or whether there was "need for additional abortion care". Following that, a nurse provider assessed the outcome of the abortion, which included a clinical history and examination, and in some cases a high sensitivity pregnancy test and/or an ultrasound exam, as per standard care. "Participants not attending in-clinic follow-up were contacted the next day by phone. Following three calls and two text messages, if no contact was made, they were considered potentially lost to follow-up (LTF). One final attempt was made to		

Study details	Participants	Interventions	Outcomes and Results	Comments
		contact all those potentially LTF prior to ceasing all participant tracing end July 2015." (p. 5) **Medical abortion:** 200mg oral mifepristone followed by 800mcg buccal/sublingual misoprostol 24 to 48 hours later. **Follow-up:** See detail under "Interventions"		
Full citation Ngoc, N. T. N., Bracken, H., Blum, J., Nga, N. T. B., Minh, N. H., Van Nhang, N., Lynd, K., Winikoff, B., Blumenthal, P. D., Acceptability and feasibility of phone follow-up after early medical abortion in Vietnam: A randomized controlled trial, Obstetrics and gynecology, 123, 88-95, 2014 **Ref Id** 816294 **Country/ies where the study was carried out** Vietnam	**Sample size** n=1433, 720 randomised to clinic follow-up and 713 to remote follow-up **Characteristics** Clinic follow-up (Clinic, n=720): Mean (SD; range) age: 27 (5.5; 18-46) years; at least 1 prior surgical abortion: n=239; at least one prior medical abortion: n=123. Remote follow-up (Remote, n=713): Mean (SD; range) age: 27 (5.9; 15-45) years; at least 1 prior surgical abortion: n=213; at least one prior medical abortion: n=129.	Randomised into 2 groups of follow-up: **Clinic follow-up (Clinic):** Clinic visit 2 weeks after mifepristone administration for a clinical assessment and transvaginal US to confirm the abortion outcome **Remote follow-up (Remote):** A study nurse explained how to take a urine-based semi-quantitative pregnancy test which the woman performed before taking mifepristone. This was also used to determine their baseline hCG range	**Outcome: Missed ongoing pregnancy (failure to detect an ongoing pregnancy)** Clinic: 0/662 (n=58 lost to follow up, unknown if any of them had an ongoing pregnancy) Remote: 1/713 **Outcome: Patient satisfaction (preferred location for managing abortion follow-up in future)** Clinic: At clinic/at home with phone follow-up/no preference: 385/256/1 of a total of 642 women Remote: At clinic/at home with phone follow-up/no preference: 72/606/8 of a total of 686 women	**Limitations** **Quality of study:** Risk of bias assessed using Cochrane Risk of Bias tool Random sequence generation: Low risk; not clearly detailed how the list was generated, but probably by computer. Allocation concealment: Low risk; sequentially numbered opaque envelopes, prepared by staff off-site. Blinding of participants and personnel: Unblinded; low risk to objective outcomes, high risk to subjective outcomes.

Study details	Participants	Interventions	Outcomes and Results	Comments
Study type Randomised controlled trial **Aim of the study** "To investigate phone follow-up with a semiquantitative urine pregnancy test and symptom checklist as a replacement for universal clinic follow-up after medical abortion." (p. 88) **Study dates** May 2010 – April 2011 **Source of funding** Anonymous donor	The groups did not differ significantly in these characteristics or in level of education. **Inclusion criteria** Literate women in good health requesting medical abortion of an intrauterine pregnancy up to 63 days gestation with a working personal phone and no known contraindications to abortion with mifepristone and/or misoprostol, who were able to complete an at-home symptom checklist **Exclusion criteria** Not reported	before the abortion. The women was then given an additional test, a urine sample cup, an information sheet explaining how to perform and interpret the test, and a questionnaire (which had the woman's baseline hCG noted on it) to use at home before a scheduled phone-based follow-up appointment 2 weeks after mifepristone administration. The symptom checklist asked the following questions: 1) Did you experience less than 2 days of heavy bleeding during treatment? 2) Are you experiencing any of the following symptoms now: breast tenderness, nausea or morning sickness, frequent urination, or exhaustion or tiredness or both? 3) Do you still feel pregnant? During the phone-based follow-up appointment (clinic staff contacted the woman), "a study nurse reviewed the pregnancy test result and checklist responses with the woman. The pregnancy test result at follow-up was compared with the baseline result and	**Outcome: Adherence to follow-up strategy (excludes early unscheduled visits)** Clinic: 652/720 Remote: 693/713 **Outcome: Unscheduled visits to the abortion service** Clinic: 10/720 Remote: 16/713 **Outcome: Surgical intervention (for ongoing pregnancy, evacuation of retained products of conception, incomplete or missed abortion, heavy bleeding, or requested by the woman)** Clinic: 36/720 Remote: 37/713	Blinding of outcome assessment: Unblinded; low risk to objective outcomes, high risk to subjective outcomes. Attrition: Low risk for all outcomes apart from patient preference and ongoing pregnancy which are at high risk with data from 642/720 (Clinic) and 686/713 (Remote) for patient preference and with data missing for 58 women in the clinic group for ongoing pregnancy. Selective reporting: Unclear risk, main outcomes included in the protocol are reported along with other outcomes not reported in the protocol. **Other information** None

Study details	Participants	Interventions	Outcomes and Results	Comments
		a drop of at least one bracket was considered a success. In the event that she had not performed the pregnancy test at the time of the call, she was asked to perform the test immediately and the nurse would call back in approximately 30 minutes." (p. 89). Women who answered yes to any of the questions, had an invalid pregnancy test, or unchanged or increased hCG were asked to come into the clinic, otherwise follow-up was considered complete. **Medical abortion:** "The most common treatment regimen used for early medical abortion services at the [4] hospitals consists of oral 200mg mifepristone followed in 24–48 hours by 800micrograms buccal misoprostol administered at home." (p. 89) **Follow-up:** Two weeks after mifepristone (see also "Interventions"). In both follow-up groups, women		

Study details	Participants	Interventions	Outcomes and Results	Comments
		who did not attend their follow-up appointment were 3 by telephone up to three times.		
Full citation Oppegaard, K. S., Qvigstad, E., Fiala, C., Heikinheimo, O., Benson, L., Gemzell-Danielsson, K., Clinical follow-up compared with self-assessment of outcome after medical abortion: A multicentre, non-inferiority, randomised, controlled trial, The Lancet, 385, 698-704, 2015 **Ref Id** 602693 **Country/ies where the study was carried out** Austria, Finland, Norway and Sweden **Study type** Randomised controlled trial **Aim of the study** "to assess whether a commercially available semiquantitative urine hCG test for self-assessment of abortion	**Sample size** 929 of 1385 women eligible for randomisation were randomised; 467 to clinic follow-up and 462 to remote assessment; ITT population consisted of 466 in clinic group (1 had missing data for primary end point) and 458 in the remote assessment group (1 withdrew consent and 3 had missing data for primary end point); per-protocol population consisted of 455 in clinic group (11 protocol violations) and 446 in the remote assessment group (12 protocol violations) **Characteristics** Clinic follow-up (n=466): Age <20 / 20-24 / 25-29 / 30-34 / 35-39 / 40-44 / 45-50 years: n=19 / 130 / 126 / 90 / 66 / 30 / 3; mean (SD) parity: 0.8 (1); median (range) gestational age: 46 (28-63) days; prior surgical abortions: 118/407; prior medical abortions: 137/391 Remote assessment (n=458):	Women randomised into 2 groups of follow-up: **Routine clinical follow-up (Clinic)** In-clinic assessment of outcome of abortion 1 to 3 weeks later by a low-sensitivity urine hCG test, measurement of hCG in serum, or ultrasonography. **Self-assessment (Remote):** Self-administration of a 2-step urine hCG DUO pregnancy test that has 2 detection thresholds of 5 and 1000IU/L, 1 to 3 weeks after the abortion to assess the outcome. Within 1 month of the initial consultation, the women underwent a telephone consultation with the clinic that aimed to ascertain if there had been expulsion of products of conception and whether the hCG test was negative for either the 1000IU/L or 5IU/L concentrations.	**Outcome: Missed ongoing pregnancy (failure to detect an ongoing pregnancy)** Clinic: 0/455 Remote: 3/446 **Outcome: Patient satisfaction (preferred self-assessment at home)** Clinic: 190/323 Remote: 272/330 (high proportion of missing data, but sensitivity analyses showed that if all the missing data were preference for assigned method [Clinic: 333/466; Remote: 400/458] or preference for non-assigned method [Clinic: 190/466; Remote: 272/458], the results still favoured statistically significantly remote assessment) **Outcome: Unscheduled telephone calls to the abortion service (at least 1 additional telephone consultation)** Clinic: 65/348 Remote: 68/346 **Outcome: Unscheduled visits to the abortion service (at least 1 additional clinic visit)** Clinic: 24/344	**Limitations** **Quality of study:** Risk of bias assessed using Cochrane Risk of Bias tool Random sequence generation: Low risk; computer-generated. Allocation concealment: Low risk; sequentially numbered opaque envelopes, unclear who prepared by, but probably adequate. Blinding of participants and personnel: Unblinded; low risk to objective outcomes, high risk to subjective outcomes. Blinding of outcome assessment: Unblinded; low risk to objective outcomes, high risk to subjective outcomes. Attrition: Low risk, data from 455/466 (Clinic) and 446/458 (Remote) included for all outcomes apart from additional telephone consultations or clinic visits, which are both at high risk of attrition bias with data

Study details	Participants	Interventions	Outcomes and Results	Comments
outcome would be as effective and manageable as outpatient follow-up after medical abortion" (p. 699) **Study dates** August 2011 - January 2013 **Source of funding** Nordic Federation of Obstetrics and Gynaecology, European Society of Contraception, Helsinki University Central Hospital, Helse Finnmark, Swedish Research Council, and Stockholm County Council and Karolinska University Hospital	Age <20 / 20-24 / 25-29 / 30-34 / 35-39 / 40-44 / 45-50 years: n=21 / 113 / 135 / 102 / 54 / 25 / 3; mean (SD) parity: 0.8 (1.1); median (range) gestational age: 46 (34-63) days; prior surgical abortions: 106/408; prior medical abortions: 128/376 **Inclusion criteria** Women aged 18 years or above requesting a medical abortion of a confirmed evolutive intrauterine pregnancy (visible intrauterine yolk sac or fetal heartbeat on US) of up to 63 days' gestation **Exclusion criteria** Women with known contraindications to medical abortion drugs or to self-administration of misoprostol at home (such as, learning difficulties or serious mental illness, or who did not have a person to accompany them during the abortion); women who were unwilling to be contacted for follow-up, or who had symptoms and signs of ectopic pregnancy or non-viable pregnancy	The women in both groups were informed that they could contact the clinic at any time with questions or health concerns. **Medical abortion:** 200mg mifepristone followed by 800mcg vaginal misoprostol 24 to 48 hours later at home. **Follow-up:** Charts review after 3 months to record additional visits due to abortion-related complications.	Remote: 30/344 **Outcome: Surgical intervention (additional surgical treatment after abortion due to sustained bleeding, incomplete abortion or both)** Clinic: 20/455 Remote: 17/446	included for only 344-348/466 (Clinic) and 344-346/458 (Remote). Selective reporting: Unclear risk, main outcomes included in the protocol are reported along with other outcomes not reported in the protocol. **Other information** Non-inferiority study Unclear how many women received ultrasound as part of the follow-up in the clinic follow-up group

Study details	Participants	Interventions	Outcomes and Results	Comments
Full citation Platais, I., Tsereteli, T., Comendant, R., Kurbanbekova, D., Winikoff, B., Acceptability and feasibility of phone follow-up with a semiquantitative urine pregnancy test after medical abortion in Moldova and Uzbekistan, Contraception, 91, 178-183, 2015 **Ref Id** 816354 **Country/ies where the study was carried out** Moldova and Uzbekistan **Study type** Randomised controlled trial **Aim of the study** "To evaluate the feasibility and acceptability of phone follow-up with a home semiquantitative pregnancy test and standardized checklist, and compare the alternative method of follow-up with in-clinic	**Sample size** n=2400 (1200 allocated to Clinic and 1200 allocated to Remote) **Characteristics** Clinic (n=1200): Median (range) age: 27 (16-47) years; median (range) parity: 1 (0-5); median (range) gravidity: 3 (1-20); median (range) gestational age: 43 (28-63) days; prior abortions: n =670. Remote (n=1200): Median (range) age: 27 (16-49) years; median (range) parity: 1 (0-5); median (range) gravidity: 3 (1-15); median (range) gestational age: 43 (30-63) days; prior abortions: n =678. **Inclusion criteria** Generally healthy women requesting and eligible for (according to clinician and clinical standards, NOS) medical abortion of pregnancies ≤63 days' gestation with no known contraindications to mifepristone and/or misoprostol. **Exclusion criteria**	Women randomised into 2 groups of follow-up: **Clinic follow-up (Clinic):** Clinic-based follow-up 2 weeks after mifepristone administration assessing the abortion outcome by clinical examination, women's report of symptoms, and ultrasound, if needed. **Remote follow-up (Remote):** At the clinic women completed a semi-quantitative pregnancy test to determine their baseline hCG range. The women was then given an additional test and a symptom checklist questionnaire to use at home before a scheduled phone-based follow-up appointment 2 weeks after mifepristone administration. The symptom checklist asked the following questions: 1) "Did you experience no or only one day of heavy bleeding (bleeding greater than your normal menses)?" 2) "Did you feel any of the following things today:	**Outcome: Missed ongoing pregnancy (failure to detect an ongoing pregnancy)** It seems there were none, but this outcome is not reliably and clearly reported **Outcome: Patient satisfaction (preferred location for managing abortion follow-up in future)** Clinic: At clinic/by phone/no preference: 349/577/273 of a total of 1199 women Remote: At clinic/by phone/no preference: 115/913/171 of a total of 1199 women **Outcome: Adherence to follow-up strategy** Clinic: 1170/1200 Remote: 1163/1200 **Outcome: Unscheduled visits to the abortion service** Clinic: 27/1200 Remote: 42/1200 **Outcome: Surgical intervention (for ongoing pregnancy, retained productions of conception, heavy/prolonged bleeding or woman's request)** Clinic: 29/1200 Remote: 29/1191	**Limitations** **Quality of study:** Risk of bias assessed using Cochrane Risk of Bias tool Random sequence generation: Low risk; computer-generated. Allocation concealment: Low risk; sequentially numbered opaque envelopes, prepared by staff off-site. Blinding of participants and personnel: Unblinded; low risk to objective outcomes, high risk to subjective outcomes. Blinding of outcome assessment: Unblinded; low risk to objective outcomes, high risk to subjective outcomes. Attrition: Low risk, data from at least 1191/1200 women in both groups included for all outcomes. Selective reporting: Unclear risk, main outcomes included in the protocol are reported along with other outcomes not reported in the protocol. **Other information**

Study details	Participants	Interventions	Outcomes and Results	Comments
follow-up after medical abortion." (p. 178) **Study dates** July 2010 - November 2012 **Source of funding** Anonymous donor	Not reported	breast tenderness, nausea or 'morning sickness', need to urinate frequently, exhaustion or tiredness?"; and 3) "Do you still 'feel pregnant' at this moment?" During the phone-based follow-up appointment (clinic staff contacted the woman), the women were asked about the results of the pregnancy test and their answers to the symptom checklist questions. Women who answered yes to any of the questions, or had unchanged or increased hCG were asked to come into the clinic for further evaluation, but the women could also return to the clinic at any time during the study. **Medical abortion:** 200mg oral mifepristone followed by 400mcg sublingual misoprostol 24 to 48 hours later. **Follow-up:** 2 weeks after mifepristone		Unclear how many women received US in clinic follow-up group

hCG: human chorionic gonadotrophin; HSPT: high sensitivity pregnancy test; ITT: intention-to-treat; LTF: lost to follow-up; mcg: micrograms; MLPT: multilevel pregnancy test; NOS: not otherwise specified; SD: standard deviation; US: ultrasound

Appendix E – Forest plots

Forest plots for review question: What is the best method of excluding an ongoing pregnancy after early (up to 10^{+0} weeks) medical abortion, when the expulsion has not been witnessed by healthcare professionals (for example, expulsion at home)?

Comparison 1. Remote follow-up versus clinic follow-up

Figure 2: Missed ongoing pregnancy

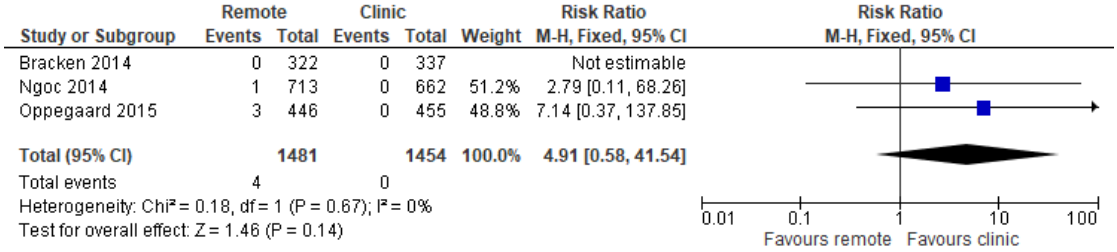
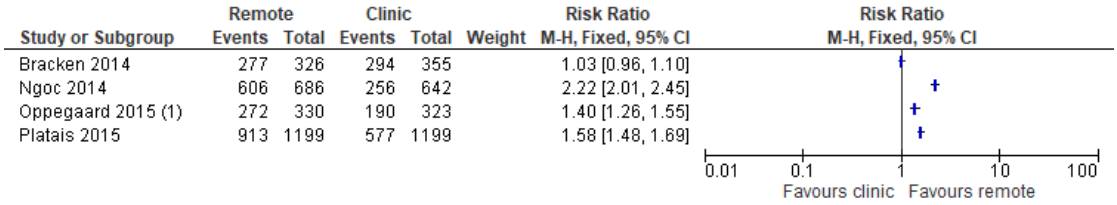


Figure 3: Patient satisfaction (Prefer remote follow up for managing abortion follow up in the future) *Not meta-analysed due to high heterogeneity (I^2 = 99%)*



Footnotes
(1) High proportion of missing data, but sensitivity analyses showed that if all the missing data were preference for assigned method...

(1) High proportion of missing data, but sensitivity analyses showed that if all the missing data were preference for assigned method [Clinic: 333/466; Remote: 400/458] or preference for non-assigned method [Clinic: 190/466; Remote: 272/458], the results still favoured statistically significantly remote assessment.

Figure 4: Adherence to follow-up strategy; *Not meta-analysed due to high heterogeneity (I^2 = 93%)*

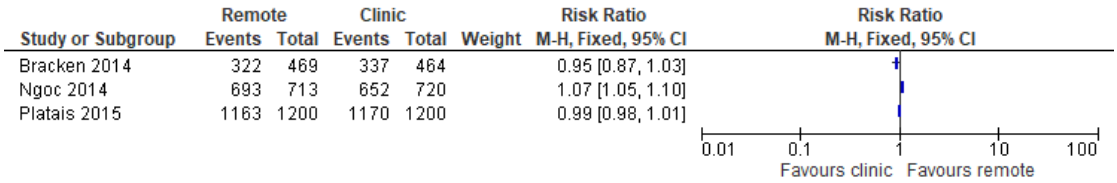
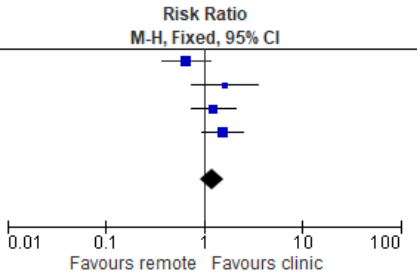


Figure 5: Unscheduled visits to the abortion service

Study or Subgroup	Remote Events	Remote Total	Clinic Events	Clinic Total	Weight	Risk Ratio M-H, Fixed, 95% CI
Bracken 2014	18	469	27	464	30.8%	0.66 [0.37, 1.18]
Ngoc 2014	16	713	10	720	11.3%	1.62 [0.74, 3.54]
Oppegaard 2015 (1)	30	344	24	344	27.2%	1.25 [0.75, 2.09]
Platais 2015	42	1200	27	1200	30.6%	1.56 [0.97, 2.51]
Total (95% CI)		**2726**		**2728**	**100.0%**	**1.20 [0.91, 1.59]**
Total events	106		88			

Heterogeneity: Chi² = 5.77, df = 3 (P = 0.12); I² = 48%
Test for overall effect: Z = 1.31 (P = 0.19)

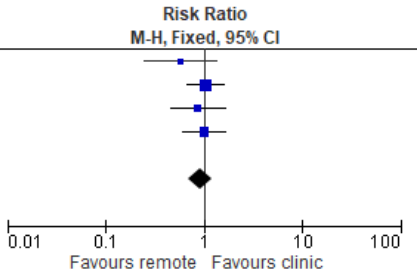


Footnotes
(1) At least 1 additional visit

Figure 6: Surgical intervention

Study or Subgroup	Remote Events	Remote Total	Clinic Events	Clinic Total	Weight	Risk Ratio M-H, Fixed, 95% CI
Bracken 2014 (1)	8	487	14	491	14.2%	0.58 [0.24, 1.36]
Ngoc 2014 (2)	37	713	36	720	36.4%	1.04 [0.66, 1.62]
Oppegaard 2015 (3)	17	446	20	455	20.1%	0.87 [0.46, 1.63]
Platais 2015 (4)	29	1191	29	1200	29.3%	1.01 [0.61, 1.68]
Total (95% CI)		**2837**		**2866**	**100.0%**	**0.93 [0.70, 1.23]**
Total events	91		99			

Heterogeneity: Chi² = 1.57, df = 3 (P = 0.67); I² = 0%
Test for overall effect: Z = 0.51 (P = 0.61)



Footnotes
(1) Surgical intervention for ongoing pregnancy, retained products of conception or medically indicated
(2) Surgical intervention for ongoing pregnancy, evacuation of retained products of conception, incomplete or missed abortion, heavy...
(3) Additional surgical treatment after abortion due to sustained bleeding, incomplete abortion or both
(4) Surgical intervention for ongoing pregnancy, retained productions of conception, heavy/prolonged bleeding or woman's request

(2) Surgical intervention for ongoing pregnancy, evacuation of retained products of conception, incomplete or missed abortion, heavy bleeding, or requested by the woman

Appendix F – GRADE tables

GRADE tables for review question: What is the best method of excluding an ongoing pregnancy after early (up to 10^{+0} weeks) medical abortion, when the expulsion has not been witnessed by healthcare professionals (for example, expulsion at home)?

Table 4: Clinical evidence profile: Comparison 1. Remote follow-up versus clinic follow-up

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Remote follow up	Clinic follow-up	Relative (95% CI)	Absolute	Quality	Importance
Missed ongoing pregnancy (follow-up 2-13 weeks)												
3 (Bracken 2014; Ngoc 2014; Oppegaard 2015)	Randomised trials	Serious[1]	No serious inconsistency	No serious indirectness[2]	Very serious[3]	None	4/1481 (0.27%)	0/1454 (0%)	RR 4.91 (0.58 to 41.54)	Not estimable	VERY LOW	CRITICAL
Patient satisfaction (Prefer remote follow-up for managing abortion follow-up in future) (follow-up 2-13 weeks) Not meta-analysed due to high heterogeneity												
4 (Bracken 2014; Ngoc 2014; Oppegaard 2015; Platais 2015)	Randomised trials	Serious[1]	Very serious[4]	Serious[5]	No serious imprecision[6]	None	Bracken 2014: 277/326 (84.97%)	Bracken 2014: 294/355 (82.82%)	RR 1.03 (0.96 to 1.1)	25 more per 1000 (from 33 fewer to 83 more)	VERY LOW	CRITICAL
							Ngoc 2014: 606/686 (88.34%)	Ngoc 2014: 256/642 (39.88%)	RR 2.22 (2.01 to 2.45)	486 more per 1000 (from 403 more to 578 more)		
							Oppegaard 2015: 272/330 (82.42%)	Oppegaard 2015: 190/323 (58.82%)	RR 1.4 (1.26 to 1.55)	235 more per 1000 (from 153		

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Remote follow up	Clinic follow-up	Relative (95% CI)	Absolute		
										more to 324 more)		
							Platais 2015: 913/1199 (76.15%)	Platais 2015: 577/1199 (48.12%)	RR 1.58 (1.48 to 1.69)	279 more per 1000 (from 231 more to 332 more)		
Adherence to follow-up strategy (follow-up 2-3 weeks) Not meta-analysed due to high heterogeneity												
3 (Bracken 2014; Ngoc 2014; Platais 2015)	Randomised trials	No serious risk of bias	Very serious[7]	Serious[8]	No serious imprecision	None	Bracken 2014: 322/469 (68.66%)	Bracken 2014: 337/464 (72.63%)	RR 0.95 (0.87 to 1.03)	36 fewer per 1000 (from 94 fewer to 22 more)	VERY LOW	IMPORTANT
							Ngoc 2014: 693/713 (97.19%)	Ngoc 2014: 652/720 (90.56%)	RR 1.07 (1.05 to 1.1)	63 more per 1000 (from 45 more to 91 more)		
							Platais 2015: 1163/1200 (96.92%)	Platais 2015: 1170/1200 (97.5%)	RR 0.99 (0.98 to 1.01)	10 fewer per 1000 (from 19 fewer to 10 more)		
Unscheduled visits to the termination service (follow-up 2-13 weeks)												
4 (Bracken 2014; Ngoc 2014; Oppegaard 2015; Platais 2015)	Randomised trials	Serious[9]	No serious inconsistency	No serious indirectness	Serious[10]	None	106/2726 (3.9%)	88/2728 (3.2%)	RR 1.2 (0.91 to 1.59)	6 more per 1000 (from 3 fewer to 19 more)	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Remote follow up	Clinic follow-up	Relative (95% CI)	Absolute		
Unscheduled telephone calls to the termination service (follow-up 13 weeks)												
1 (Oppegaard 2015)	Randomised trials	Serious[11]	No serious inconsistency	No serious indirectness	Very serious[3]	None	68/346 (19.7%)	65/348 (18.7%)	RR 1.05 (0.78 to 1.43)	9 more per 1000 (from 41 fewer to 80 more)	VERY LOW	IMPORTANT
Surgical intervention (follow-up 2-13 weeks)												
4 (Bracken 2014; Ngoc 2014; Oppegaard 2015; Platais 2015)	Randomised trials	Serious[9]	No serious inconsistency	Serious[5]	Serious[10]	None	91/2837 (3.2%)	99/2866 (3.5%)	RR 0.93 (0.7 to 1.23)	2 fewer per 1000 (from 10 fewer to 8 more)	VERY LOW	IMPORTANT

CI: confidence interval; MID: minimally important difference; RR: relative risk

[1] All the studies were unblinded, and in one of them there was high risk of attrition bias.

[2] In one of the studies, it was unclear how many women received ultrasound as part of the follow-up in the clinic follow-up group.

[3] The 95% CI crosses two MID thresholds.

[4] Very high heterogeneity (I^2 = 99%)

[5] In two of the studies, it was unclear how many women received ultrasound as part of the follow-up in the clinic follow-up group. Moreover, the outcome itself is indirect and is only reported because none of the studies reported the target outcome of patient satisfaction.

[6] The results are not downgraded for imprecision as they have already been downgraded two levels for inconsistency and they are in agreement that women either prefer remote follow-up (Ngoc 2014, Oppegaard 2015 and Platais 2015) or that there is no difference between their preference for remote or clinic follow-up (Bracken 2014)

[7] Very high heterogeneity (I^2 = 93%)

[8] In the largest study (Platais 2015), it was unclear how many women received ultrasound as part of the follow-up in the clinic follow-up group.

[9] All the studies were unblinded.

[10] The 95% CI crosses one MID threshold

[11] The study was unblinded.

Table 5: Clinical evidence profile: Comparison 2. Remote follow-up 'Multi-level pregnancy test' versus remote follow-up 'High sensitivity pregnancy test'.

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multi-level pregnancy test	High sensitivity pregnancy test	Relative (95% CI)	Absolute	Quality	Importance
Missed ongoing pregnancy (follow-up 2 weeks)												
1 (Blum 2016)	Randomised trials	No serious risk of bias	No serious inconsistency	No serious indirectness	Very serious[1]	None	0/293 (0%)	0/291 (0%)	Not estimable	Not estimable	LOW	CRITICAL
Patient satisfaction (Prefer remote follow-up for managing abortion follow-up in future) (follow-up 2 weeks)												
1 (Blum 2016)	Randomised trials	Serious[2]	No serious inconsistency	Serious indirectness[3]	No serious imprecision	None	257/293 (87.7%)	263/291 (90.4%)	RR 0.97 (0.92 to 1.03)	27 fewer per 1000 (from 72 fewer to 27 more)	MODERATE	CRITICAL
Unscheduled visits to the termination service (follow-up 2 weeks)												
1 (Blum 2016)	Randomised trials	Serious[2]	No serious inconsistency	No serious indirectness	No serious imprecision	None	5/293 (1.7%)	56/291 (19.2%)	RR 0.09 (0.04 to 0.22)	175 fewer per 1000 (from 150 fewer to 185 fewer)	MODERATE	IMPORTANT
Surgical intervention (follow-up 2 weeks)												
1 (Blum 2016)	Randomised trials	Serious[2]	No serious inconsistency	No serious indirectness	Very serious[4]	None	0/293 (0%)	1/291 (0.34%)	RR 0.33 (0.01 to 8.09)	2 fewer per 1000 (from 3 fewer to 24 more)	VERY LOW	IMPORTANT

CI: confidence interval; MID: minimally important difference; RR: relative risk

[1] The study is not powered to detect this outcome.

[2] The study was unblinded.

[3] The outcome itself is indirect and is only reported because the study reported the target outcome of patient satisfaction.

[4] The 95% CI crosses two MID thresholds.

Table 6: Clinical evidence profile: Comparison 3. Remote follow-up 'Demonstration' versus remote follow-up 'Instruction'.

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Demonstration	Instruction	Relative (95% CI)	Absolute	Quality	Importance
Missed ongoing pregnancy (follow-up 2-4 weeks)												
1 (Constant 2017)	Randomised trials	Serious[1]	No serious inconsistency	No serious indirectness	Very serious[2]	None	1/218 (0.46%)	0/208 (0%)	RR 2.86 (0.12 to 69.89)	Not estimable	VERY LOW	CRITICAL
Patient satisfaction (Prefer remote follow-up for managing abortion follow-up in future) (follow-up 2-4 weeks)												
1 (Constant 2017)	Randomised trials	Serious[3]	No serious inconsistency	Serious indirectness[4]	No serious imprecision	None	228/231 (98.7%)	223/227 (98.2%)	RR 1 (0.98 to 1.03)	0 fewer per 1000 (from 20 fewer to 29 more)	LOW	CRITICAL

CI: confidence interval; MID: minimally important difference; RR: relative risk
[1] High risk of attrition bias.
[2] The 95% CI crosses two MID thresholds.
[3] High risk of attrition bias and only the clinic staff, not the women or the field workers, were blinded.
[4] The outcome itself is indirect and is only reported because the study reported the target outcome of patient satisfaction.

Appendix G – Economic evidence study selection

Economic evidence for review question: What is the best method of excluding an ongoing pregnancy after early (up to 10^{+0} weeks) medical abortion, when the expulsion has not been witnessed by healthcare professionals (for example, expulsion at home)?

No economic evidence was identified which was applicable to this review question.

Appendix H – Economic evidence tables

Economic evidence tables for review question: What is the best method of excluding an ongoing pregnancy after early (up to 10^{+0} weeks) medical abortion, when the expulsion has not been witnessed by healthcare professionals (for example, expulsion at home)?

No economic evidence was identified which was applicable to this review question.

Appendix I –Economic evidence profiles

Economic evidence profiles for review question: What is the best method of excluding an ongoing pregnancy after early (up to 10^{+0} weeks) medical abortion, when the expulsion has not been witnessed by healthcare professionals (for example, expulsion at home)?

No economic evidence was identified which was applicable to this review question.

Appendix J – Health economic analysis

Economic analysis for review question: What is the best method of excluding an ongoing pregnancy after early (up to 10^{+0} weeks) medical abortion, when the expulsion has not been witnessed by healthcare professionals (for example, expulsion at home?

No economic analysis was conducted for this review question.

Appendix K – Excluded studies

Excluded studies for review question: What is the best method of excluding an ongoing pregnancy after early (up to 10^{+0} weeks) medical abortion, when the expulsion has not been witnessed by healthcare professionals (for example, expulsion at home)?

Clinical studies

Study	Reason for Exclusion
Clark,W., Bracken,H., Tanenhaus,J., Schweikert,S., Lichtenberg,E.S., Winikoff,B., Alternatives to a routine follow-up visit for early medical abortion, Obstetrics and Gynecology, 115, 264-272, 2010	Non-randomised trial
Constant, D., Daskilewicz, K., Harries, J., Myer, L., Gemzell-Danielsson, K., Instruction-only versus demonstration of a low sensitivity pregnancy test for self-assessment of medical abortion in South Africa; a multicentre non-inferiority randomised controlled trial, European Journal of Contraception and Reproductive Health Care, 21, 52-53, 2016	Conference abstract only - full text available
Constant, D., Daskilewicz, K., Harries, J., Myer, L., Gemzell-Danielsson, K., Self-assessment of medical abortion using a low-sensitivity pregnancy test, checklist and text messages in the South African public sector: A randomized controlled trial, Contraception, 92 (4), 373, 2015	Conference abstract only - full text available
Constant, D., de Tolly, K., Harries, J., Myer, L., Assessment of completion of early medical abortion using a text questionnaire on mobile phones compared to a self-administered paper questionnaire among women attending four clinics, Cape Town, South Africa, Reproductive Health Matters, Part S1. 22, 83-93, 2015	All women received in-person assessment; randomisation was to standard care versus standard care and text questionnaire
Dabash, R., Shochet, T., Hajri, S., Chelli, H., Hassairi, A. E., Haleb, D., Labassi, H., Sfar, E., Temimi, F., Koenig, L., Winikoff, B., Self-administered multi-level pregnancy tests in simplified follow-up of medical abortion in Tunisia, BMC Women's Health, 16 (1) (no pagination), 2016	Non-randomised trial
de Tolly, K. M., Constant, D., Integrating mobile phones into medical abortion provision: intervention development, use, and lessons learned from a randomized controlled trial, JMIR MHealth and UHealthJMIR Mhealth Uhealth, 2, e5, 2014	Results of the randomised component of the trial not reported in this paper (reported in Constant 2017)
Debby,A., Malinger,G., Harow,E., Golan,A., Glezerman,M., Transvaginal ultrasound after first-trimester uterine evacuation reduces the incidence of retained products of conception, Ultrasound in Obstetrics and Gynecology, 27, 61-64, 2006	Population inconsistent with protocol: surgical abortion
Godfrey, E. M., Anderson, A., Fielding, S. L., Meyn, L., Creinin, M. D., Clinical utility of urine pregnancy assays to determine medical abortion outcome is limited, Contraception, 75, 378-382, 2007	Women received all methods of assessment for ongoing pregnancy; this component of the trial was not randomised

Study	Reason for Exclusion
Grossman, D., Grindlay, K., Alternatives to ultrasound for follow-up after medication abortion: A systematic review, Contraception, 83, 504-510, 2011	Non-randomised trials
Iyengar, K., Paul, M., Iyengar, S. D., Klingberg-Allvin, M., Essen, B., Bring, J., Soni, S., Gemzell-Danielsson, K., Self-assessment of the outcome of early medical abortion versus clinic follow-up in India: A randomised, controlled, non-inferiority trial, The Lancet Global Health, 3, 2015	In-person assessment did not use ultrasound
Nct,, Comparison of the Effectiveness of Treatment With Mifepristone and Misoprostol at the Same Time Compared to the Administration of Drugs at a 48-hour Interval for Medical Abortion, Https://clinicaltrials.gov/show/nct03440866, 2018	Comparison not in PICO
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Raymond, E. G., Shochet, T., Blum, J., Sheldon, W. R., Platais, I., Bracken, H., Dabash, R., Weaver, M. A., Ngoc, N. T. N., Blumenthal, P. D., Winikoff, B., Serial multilevel urine pregnancy testing to assess medical abortion outcome: a meta-analysis, Contraception, 95, 442-448, 2017	Includes non-randomised trials; no new studies identified
Raymond, E. G., Shochet, T., Bracken, H., Low-sensitivity urine pregnancy testing to assess medical abortion outcome: A systematic review, Contraception., 2018	Includes non-randomised trials; no new studies identified

PICO: population, intervention, comparison and outcomes

Economic studies

No economic evidence was identified for this review. See supplementary material 2 for further information.

Appendix L – Research recommendations

Research recommendations for question: What is the best method of excluding an ongoing pregnancy after early (up to 10^{+0} weeks) medical abortion, when the expulsion has not been witnessed by healthcare professionals (for example, expulsion at home)?

No research recommendations were made for this review question.