Conclusions: This real-world evidence shows that telehealth medication abortion care is safe and effective. Telehealth can increase access to this vital service while maintaining patient safety.

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O04

PREVALENT BUT NOT INEVITABLE: MAPPING CONTRACEPTION DESERTS ACROSS THE AMERICAN STATES

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Objectives: To provide a socio-spatial analysis of the allocation of Title X funding, the federal government's only program dedicated to reproductive healthcare; to systematically assess whether access to publicly-funded reproductive health resources are distributed in an equitable way across the US; to utilize an innovative measure of potential access that incorporates both spatial and aspatial variables to ascertain the size, scope, and demographic characteristics of geographies of concentrated disadvantage, which we refer to as "contraception deserts."
Methods: We employed methods that incorporated geographic information systems (GIS) and statistical/spatial analysis. We used the integrated two-step floating catchment area (I2SFCA) method, which incorporates both spatial (eg, distance, rurality/urbanicity) and aspatial (eg, poverty) variables, to more accurately develop a measure of potential access to Title X–funded clinics (FY2019). To map contraception deserts and to determine the demographic profile of these spaces of inequity, we used US Census data (at the tract level) and Title X–clinic location data from the Office of Population Affairs.
Results: GIS mapping techniques illustrate that significant proportions of the US can be characterized as contraception deserts, though with a great deal of variability in size across them. However, historically marginalized racial groups and those experiencing poverty are disproportionately represented in contraception deserts.
Conclusions: Given the various ways Title X can be implemented across states, results reveal that contraception deserts are prevalent but not inevitable. Speaking to policy implication, the results show that with strategic siting decisions, state-level Title X networks can mitigate inequitable access to federal resources.

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O05

CABERGOLINE FOR LACTATION INHIBITION AFTER SECOND-TRIMESTER ABORTION OR LOSS: A RANDOMIZED CONTROLLED TRIAL

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Objectives: To assess cabergoline's efficacy at decreasing lactation after second-trimester abortion or loss.
Methods: This is a double-blinded, block-randomized superiority trial (IRB approved, NCT04701333) comparing cabergoline 1mg once to placebo for preventing bothersome breast engorgement after second-trimester uterine evacuation. April 2021-June 2022, we enrolled pregnant people 18-28-weeks gestation, English- or Spanish-speaking, without contraindication to the study drug. Participants completed a validated, piloted, electronic survey at baseline and through two weeks post-procedure assessing breast symptoms, side-effects, and bother at each time point. Our primary outcome is breast symptoms on day 4; we planned to enroll 80 patients to show a 30% difference in breast symptoms (80% power, $\alpha = 0.049$). A sub-group of participants returned for serum prolactin levels.
Results: After screening 150 patients, we enrolled 73 participants. Baseline demographics were balanced between groups: median gestational age 21 weeks (range: 18-26), 56% nulliparous, 35% self-identified as Hispanic, 37% with public insurance. At baseline, reported breast symptoms were similar between groups. At day 4, significantly fewer participants receiving cabergoline reported any symptoms compared to placebo (27.8% vs 97.0%, $p<0.0001$) and fewer reported significant bother (2.8% vs 29.7%, $p=0.002$). These differences persisted through day 14. Reported side-effects ($p=0.31$) were similar between groups: most common were constipation (44%), fatigue (32%), and headache (29%). Serum prolactin was similar at baseline. On day 4, mean serum prolactin was 6.5ng/mL (std dev 2.2) for those receiving cabergoline and 18.0ng/mL (std dev 5.9) for placebo ($p=0.04$).
Conclusions: Cabergoline is an effective strategy to prevent breast symptoms following second-trimester abortion or loss.

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O06

SELF-MANAGED ABORTION OUTCOMES FOR PREGNANCIES OF 9–22 WEEKS' GESTATION: RESULTS FROM A PROSPECTIVE, OBSERVATIONAL STUDY IN THREE COUNTRIES

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Objectives: The literature on self-managed abortion at later gestations is sparse, and more information is urgently needed in the US and elsewhere where this practice may become increasingly common. This analysis offers novel results on the effectiveness of self-managed medication abortion among people with pregnancies >9 weeks.
Methods: In 2019–2020, as a part of The Studying Accompaniment Model Feasibility and Effectiveness (SAFE) Study, we recruited callers to safe-abortion hotlines in Argentina, Nigeria, and Southeast Asia who were seeking support for self-managed medication abortion. Via phone, participants completed a baseline survey prior to taking the medications, and up to three follow-up surveys over four weeks to ascertain abortion outcomes.
Results: We recruited 1,351 participants, of which 264 self-managed an abortion for a pregnancy that was 9–22 weeks' gestation; 149 (56%) respondents used mifepristone and misoprostol, while 115 (44%) used misoprostol alone. One week after taking the pills, 222 (91%) participants had a complete abortion — 87% with pills alone, and 4% with additional intervention. At last follow-up, 95% of participants had had a complete abortion (89% with pills alone, 5% with additional intervention; 93% of combined regimen users, and 97% of misoprostol-alone users). A minority of participants sought healthcare at a clinic or hospital at any point (30% of combined regimen users, 15% of misoprostol-alone users). Among those seeking care, most (60%) did so to confirm abortion completion, and a small minority (1.5%) received treatment indicative of a serious complication (blood transfusion).
Conclusions: Self-managed medication abortion can be a safe and effective option for ending a pregnancy at 9+ weeks' gestation.

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O07

THE IMPACT OF THE TEXAS ABORTION BAN ON GESTATIONAL AGE AT TIME OF ABORTION IN A LARGE-VOLUME COLORADO CLINIC

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Objectives: To assess changes in the proportion of Texas residents, gestational age at time of abortion, and rates of second-trimester abortion, at a university-affiliated abortion clinic in Colorado after Texas passed Senate Bill 8 (SB8), which prohibits abortions >6 weeks' gestation.
Methods: We focused on all patients obtaining an abortion ≤22 weeks' gestation at a university-affiliated clinic between January 2018 and mid-April 2022. We created two time periods: before SB8 (January 2018–August 2021) and after SB8 (September 2021–April 2022). We compared the proportion of Texas residents obtaining care and gestational age categories before and after SB8 using chi-square tests. We determined the adjusted odds of a second-trimester abortion (≥13 weeks) after SB8 using logistic regression models adjusted for gravida, parity, age, and the proportion of Texas residents.
Results: We assessed 4,358 abortions; 3,630 before and 728 after SB8. After SB8, the proportion of patients who were Texas residents increased from 1% to 17%, $p<0.001$. Among all patients, abortions ≥15 weeks increased from 11% to 21%, $p<0.01$, and surgical abortions at 6–10 weeks decreased from 46% to 33%, $p<0.001$. There was no change in abortions at 11–14 weeks. The proportion of second-trimester abortions increased from 17% to 27%, $p<0.001$ and the odds nearly doubled after SB8 (aOR1.9, 95% CI, 1.6–2.3). Although higher among Texas residents (aOR, 2.6, 95% CI,1.1–6.9), the odds of a second-trimester abortion also increased among Colorado residents (aOR,1.8, 95% CI, 1.4–2.2).
Conclusions: Post-*Roe* abortion bans will likely delay care not only for people forced to seek care out of state, but for residents of states maintaining abortion access.

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