questions but the indication, women could refer to the label while answering. We used descriptive, chi-square and regression analyses to assess comprehension of key concepts.

Results: 100 women aged 16-24 (26%), 25-34 (37%) and 35-45 (37%) years participated. Most were single (73%) or married (16%) with education: less than high school (20%), high school (43%), or university (16%). The majority reported prior sexual intercourse (91%), pregnancy (75%), and contraception (male condom, 45%). In terms of comprehension, the indication was reported 'to end a pregnancy' by 79% of participants (range: 43-85%, for low-high literacy). Most (74%) could report the maximum number of gestational weeks for use (range: 26-76% for low-high literacy). Participants (87%) identified incorrect use (taking only 2 misoprostol) but struggled to correctly identify timing (57% reported a 36-hourinterval between mifepristone and misoprostol as incorrect). Messages clear to participants (>90%) regardless of literacy were when to consult a doctor before use (history of anemia or ectopic), to respect the mifepristone-misoprostol interval, when to seek medical attention (heavy, prolonged or no bleeding) and that fertility returns quickly after abortion.

Conclusions: Our prototype over-the-counter label for a combined mifepristone-misoprostol product for medical abortion in early pregnancy was moderately understandable to participants. To demonstrate an understanding of at least 80% for all key concepts, the prototype label for a combined medical abortion product requires revision.

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Intrafetal digoxin as an adjuvant for dilation and evacuation at 20 to 24 weeks' gestation: a randomized, double-blind, placebo-controlled trial

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Introduction: The benefit of inducing fetal demise before dilation and evacuation (D&E) remains unclear. Although one study demonstrated no effect on procedure time, some providers believe that inducing fetal demise makes the D&E quicker and may lead to fewer complications. The safety of D&E without inducing fetal demise is well established and a digoxin injection may pose unnecessary risks. We sought to evaluate the effect of inducing fetal demise on procedure duration for D&Es at 20 to 24 weeks.

Method: We conducted a multi-center, randomized, double-blind, placebo-controlled trial of intrafetal digoxin versus placebo before D&E at 20 to 24 weeks. We enrolled subjects between February 2017 and May 2018 from four abortion clinics in San Francisco, CA, Long Beach, CA, Los Angeles, CA, and Portland, OR. Participants received a blinded intrafetal injection of either 1mg digoxin or an equivalent volume saline the day before D&E. We stratified randomization by gestational group (20-22 weeks, 22-24 weeks). Our primary outcome was procedure duration, measured as the time from first instrument in the uterus to last instrument out of the uterus. Secondary outcomes included total procedure duration, provider assessment of ease of procedure, achievement of fetal demise, measured blood loss, and complications. We used an intention to treat analysis.

Results: Of the 321 eligible patients, we enrolled 190 and randomized 178. Baseline characteristics were similar between groups. The difference in mean procedure time between digoxin and placebo was not significant either in the overall group (6.8 vs 7.2 minutes, p=0.70) or by gestational group: 5.5 vs 5.0 minutes for the 20-22 week group (p=0.48) and 11.7 vs 15.3 minutes for the 22-24 week group (p=0.11). Complications were similar between groups, as were nausea and vomiting, both post-injection and post-D&E.

Conclusions: Inducing fetal demise with digoxin does not shorten procedure duration overall but may shorten procedure duration for 22-24 week D&Es. Complications with digoxin were rare. D&E providers may consider offering digoxin to patients undergoing abortion at 22 to 24 weeks; patients' preferences should be considered in the decision to induce fetal demise.

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What happens beyond the clinic?: New data on home abortion providers and practices in North America

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Introduction: Recent political threats in the United States brought increased attention to abortions happening outside formal healthcare systems. Clinic-based recruitment presents methodological challenges when researching this topic, and literature on abortion provision by home abortion providers in North America is lacking. Surveying this population creates a unique opportunity to better understand these phenomena. This study describes: 1) current trends and scope of home abortion providers in North America; 2) their characteristics, practices, and experiences, and 3) the people who access their abortion services.

Method: In February 2018, we created and pilot-tested an anonymous online survey that collected data on the demographics and geographic location of home abortion providers and the people accessing their services, and home abortion providers' practices and experiences. We distributed the survey using community engagement with a home abortion provider network and established an anonymous phone line for questions and concerns. We downloaded data from REDCap and grouped and coded open-response survey questions, calculated categorical frequencies, and used descriptive statistics to identify trends and outliers in the data.

Results: We received 75 responses of which 68 (91%) were eligible after self-screening. The majority of respondents were located in the United States (73%) living in 19 states, and 24% were located in 4 Canadian provinces. Home abortion providers reported serving people across North America including 39 U.S. states and territories, and 8 Canadian provinces. Home abortion providers reported practicing for an average of 5 years and serving between 1 and 40 people in the past year. Herbs and misoprostol were used most frequently with reported effectiveness between 91-100%. Home abortion providers detailed a range of in-person and remote services, and 88% reported wanting to collaborate with clinics.