Consultation website: https://www.gov.uk/government/consultations/home-use-of-both-pills-for-early-medical-abortion/home-use-of-both-pills-for-early-medical-abortion-up-to-10-weeks-gestation

Deadline 26 February 2021

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Question 1: Do you consider that the temporary measure has had an impact on the provision of abortion services for women and girls accessing these services with particular regard to safety?

a) Yes, it has had a positive impact

b) Yes, it has had a negative impact

c) It has not had an impact

d) I don't know

[If necessary, please provide text to support your answer]

- Abortion is a very safe procedure and is safer than continuing a pregnancy to term in all instances.
- National evidence since the introduction of telemedicine abortion has shown that the temporary measure has had a positive impact on safety.
    - A recent cohort study in England and Wales compared the safety of 52,142 medical abortions (85% of all abortions that occurred during the study period) before and after the introduction of telemedicine services and found no differences in abortion completion rates or adverse events between abortions provided via telemedicine services and those provided in-person with routine ultrasound scanning. Mean waiting times were 4.2 days shorter in the telemedicine-hybrid cohort, and 40% were provided at ≤6 weeks' gestation compared to 25% in the traditional cohort, which will also improve the safety of services as earlier gestation abortions are known to have lower complication rates.
    - Bpas data from April-July 2020 shows that complications (continuing pregnancy) for early medical abortions were lower (0.28% vs 1.12%) than in the same period in 2019, possibly due to clients being able to pick the best time to start their procedure, rather than having to fit it around their commitments and in-clinic appointments.
- International evidence has also proven the safety of offering medical abortion through telemedicine or remote models of care. A 2019 systematic review of published literature on telemedicine for abortion found it to be as safe as in-person abortion care, with similar (low) rates of incomplete abortion, continuing pregnancy, hospitalisation and blood transfusion.
    - Prior to the temporary approval, most medical abortions were already managed at home in England and Wales, since the 2018 change in policy that allowed misoprostol to be taken at home. Medical abortion can be managed safely and effectively at home, as proven by many studies. A systematic review comparing medical abortion practised at

home and in clinics found no differences in effectiveness or acceptability between these groups. Complications due to abortion were extremely rare.

- Safety concerns raised by groups that oppose telemedicine abortion include the risk of not having ultrasound scanning for gestational age assessment and for ectopic pregnancy detection. However, routine pre-abortion ultrasound scanning is not recommended by multiple national and international bodies. Self-report of last menstrual period is an effective way to estimate gestational age. Slight inaccuracies in gestational age are not expected to result in safety concerns as the World Health Organisation recommend that abortions can be self-managed without direct supervision of a healthcare provider for pregnancies < 12 weeks gestation. Routine ultrasound screening for ectopic pregnancy among symptom-free women seeking abortion is associated with a high rate of false positives, and ultrasound has low sensitivity for excluding ectopic pregnancies at earlier gestations, as is the case for telemedicine services. NICE guidelines recommend a symptom-based approach for detection of ectopic pregnancy. The cohort study comparing medical abortion safety before and after the introduction of telemedicine found that the incidence of ectopic pregnancy was equivalent in both cohorts (0.2%, p=0.796), with no significant difference in the proportions being treated after abortion (0.01% vs 0.03%, p=0.123). In the same study, just 0.04% of cases the abortion appeared to have been provided at over 10 weeks' gestation; these abortions were all completed at home without additional medical complications.

Question 2: Do you consider that the temporary measure has had an impact on the provision of abortion services for women and girls accessing these services with particular regard to accessibility?

a) Yes, it has had a positive impact

b) Yes, it has had a negative impact

c) It has not had an impact

d) I don't know

[If necessary, please provide text to support your answer]

- Accessibility of abortion care has improved since the temporary measures were introduced.
- The requirement to visit a provider for an in-person consultation requires people to travel long distances in some cases, and to take time off work, and find and pay for childcare. A 2018 study of 519 women in Great Britain who had contacted online sellers of medication abortion found that the access barriers to NHS-funded services faced by these women included long waiting times, long distances, work or childcare commitments, concerns about privacy and quality, perceived stigma, preference for privacy and comfort of taking pills at home, and controlling circumstances such as partner violence or partner/family control.

- Since the temporary approval, there has been an 88% decline in demand for medical abortion from the same online provider (Women on Web) in Great Britain - the only European country in this study to see a decline in demand for online access to MA during the Covid-19 pandemic. This suggests that many of the access barriers faced when trying to access abortion care in Britain have been addressed by the provision of abortion through telemedicine.
- Telemedicine has resulted in a drop in average gestation, suggesting an improvement in accessibility and reduced waiting times. Recent data indicate that 40% of abortions are now performed before 6 weeks, compared to only 25% prior to the change in regulation.

Question 3: Do you consider that the temporary measure has had an impact on the provision of abortion services for women and girls accessing these services with particular regard to privacy and confidentiality of access?

a) Yes, it has had a positive impact

b) Yes, it has had a negative impact

c) It has not had an impact

d) I don't know

[If necessary, please provide text to support your answer]

- Allowing both pills to be taken at home and removing the requirement for a clinic visit has improved privacy and confidentiality of access.
- Abortion providers ask all clients whether they are able to talk confidentially and if they feel safe to speak privately on the phone.
- As a clinic visit is not needed, women and pregnant people do not need to disclose their medical care to people that they do not wish to involve - such as their family, employees or childcare.
- Individuals in coercive relationships or who face controlling behaviour from people they live with can find it particularly difficult to make a clinic visit, so offering phone-based care can improve confidentiality and access.
- Removing the requirement for a clinic visit also improves privacy and confidentiality because abortion clients do not have to be subjected to anti-abortion protests. More than half of women who had an abortion in 2019 had to attend a clinic or hospital that was targeted by these groups, and have to experience being watched or harassed.
- However, it is important that the option of clinic-based care (including MVA) is still available, as some people may not feel that managing the medical abortion at home is confidential, if they find it difficult to hide the process from people they live with, particularly if living in crowded accommodation. Offering telemedicine appointments can increase the availability of in-person appointments for individuals who need them.

Question 4: Do you consider that the temporary measure has had an impact on the provision of abortion services for those providing services? This might include greater workforce flexibility, efficiency of service delivery, value for money etc.

a) Yes, it has had a positive impact

b) Yes, it has had a negative impact

c) It has not had an impact

d) I don't know

[If necessary, please provide text to support your answer]

- Providing medical abortion services via telemedicine has had a positive impact on providers and on the quality, efficiency and flexibility of care that they are able to provide.
- Telemedicine users no longer need to wait for a prolonged period in a clinic while the requirements for the Abortion Act are met, meaning care is more patient-centred. Some NHS providers have previously required women to attend multi-day appointments, or receive a referral which is contrary to NICE guidance so that their HSA1 abortion form can receive one signature – as the abortion service is run by a single doctor. They report that the change in regulation has allowed them to do this work behind the scenes – so women are not delayed or forced to attend unnecessary appointments in order to access care.
- Providers report being able to better manage clinics and provide additional time to clients who may have more complex reasons for attending care in person.
- Reduced waiting times mean that women are treated earlier in pregnancy which can reduce the (low) risk of complications, and in the medium to long term can reduce the costs of providing an early medical abortion services, allowing commissioning groups to focus on improving service provision for later or more complex care, contraception or STI services.
- NHS services have reported that telemedicine has enabled them to provide services despite staff being redeployed to deal with Covid – indicating that high quality abortion services can now be provided with fewer staff.
- Telemedicine has been accompanied by self-referral into abortion services in a number of areas where this was not already in place, which has reduced pressure on sexual health, contraceptive, and GP services which may previously refer patients to the service.
- A systematic review of economic analyses of telemedicine services found that this care model was cost effective for a range of services.

Question 5: Have other NHS services been affected by the temporary measure?

a) Yes [please provide details of which services]

b) No

c) I don't know

[If necessary, please provide text to support your answer]

- Bpas data from April-July 2020 shows that complications (continuing pregnancy) for early medical abortions were lower (0.28% vs 1.12%) than in the same period in 2019, and the risk of major complications fell from 0.09% to 0.03%. Although independent abortion service providers provide follow up care and in-clinic appointments for clients with suspected incomplete abortions or retained productions of conception, reduction in complications may also reduce the need for treatment of abortion complications in NHS services.
- NHS services have reported that telemedicine has enabled them to provide services despite staff being redeployed to deal with Covid – indicating that high quality abortion services can now be provided with fewer staff.
- Telemedicine has been accompanied by self-referral into abortion services in a number of areas where this was not already in place, which has reduced pressure on sexual health, contraceptive, and GP services which may previously refer patients to the service.

Question 6: What information do you consider should be given to women around the risks of accessing pills under the temporary measure if their pregnancy may potentially be over 10 weeks gestation?

[free text answer]

- Abortion providers include information about this potential risk in their routine discussions with clients in the same way as other kinds of risks and complications of abortion treatment.
- The risk of people accessing medical abortion over 10 weeks gestation through telemedicine is very low. The cohort study comparing medical abortion safety before and after the introduction of telemedicine found that just 0.04% of cases the abortion appeared to have been provided at over 10 weeks' gestation; these abortions were all completed at home without additional medical complications.
- The WHO recommends the medical abortion process can be self-managed with pregnancies <12 weeks of gestation without the direct supervision of a health care provider, although evidence is more limited for pregnancies > 10 weeks. Beyond 12 weeks, the risk of serious complications are rare and a study from Indonesia found that over 90% of women using medical abortion with the help of a hotline after 12 weeks ended their pregnancy safely and successfully.
- The risks of using medical abortion at home after 10 weeks therefore need to be explained (alongside other medical risks) but not over-stated, and should focus on how the process may feel different after 10 weeks, may have slightly higher risks of complications, and may require more medications and support.

Question 7: Outside of the pandemic do you consider there are benefits or disadvantages in relation to safeguarding and women's safety in requiring them to make at least one visit to a service to be assessed by a clinician?

a) Yes, benefits

b) Yes, disadvantages

c) No

d) I don't know

[If necessary, please provide text to support your answer]

- Every woman is asked by abortion providers whether they are safe at home. This is a routine part of abortion care, no matter how or where care is provided.
- Concerns have been raised about the impact of telemedicine abortion on safeguarding, but independent provides report either the same rate of, or an increase in, detection of safeguarding issues before and after the introduction of telemedicine. BPAS reported that in the first three months of their Pills by Post service, 10% of clients underwent an enhanced safeguarding risk assessment – a 12% increase compared to March 2020.
- Clinicians have reported that telemedicine service users feel more comfortable to disclose safety concerns over the phone than they would in an in-person clinic visit, and may feel more comfortable to speak freely when in the comfort of their own home.
- The option of telemedicine may improve access to services for those who otherwise would not be able to make a clinic visit due to controlling or abusive home circumstances, as previously identified in a study of women who were not able to access abortion through the British health system.
- The requirement for a clinic visit also increases the risk to women's safety due to the experience of anti-abortion protesters outside abortion clinics.
- Abortion services continue to provide in-person care where telephone consultations raise safeguarding concerns such as safety or privacy at home, ability to consent, or wider safety concerns surrounding existing children or statutory concerns such as Female Genital Mutilation. Ensuring that women have the choice of both a telemedicine service or a clinic-based service will continue to be important.

Question 8: To what extent do you consider making permanent home use of both pills could have a differential impact on groups of people or communities?

For example, what is the impact of being able to take both pills for EMA at home on people with a disability or on people from different ethnic or religious backgrounds?

[free text answer]

- Telemedicine enables providers to tailor care to individual women and their needs. Some women are disproportionately likely to encounter difficulties in accessing in-person care if required – including mothers, victim-survivors of sexual violence, women experiencing domestic abuse, teenage women and girls, women from deprived areas, LGBTI people, disabled women, BME women, migrant women, homeless women, women with mental health or substance use issues, and women with insecure immigration status.
- Younger women and girls under 18 are disproportionately likely to lack the ability to travel for care as a result of lack of access to private transport, or the money to travel on public transport. Younger women may be more likely to live with their family or parents and may wish to conceal their pregnancy or abortion, so telemedicine can improve access and privacy for this group.
- Disabled women may have different access needs that affect their capacity to visit hospitals and clinics in-person or mean that they have to forgo privacy in order to have support to access premises.
- Members of all communities in the UK access abortion services, even where their cultural or religious background disagrees with abortion access. These women are disproportionately likely to need to access care privately and without the need to travel – which is only ultimately available via telemedicine.
- The cost of travel to clinics or loss of pay for taking time off to attend in-person appointments may disproportionately affect lower-income groups.
- Women's greater provision of care and childcare may make travel to appointments more difficult or expensive. This is particularly acute where women are caring for a child with special needs.
- Women win abusive and controlling relationships may find it easier to access telemedical services with increased privacy and the ability to better control the timing of their abortion.

Question 9: To what extent do you consider that making permanent home use of both pills for EMA would increase or reduce the difference in access to abortion for women from more deprived backgrounds or between geographical areas with different levels of disadvantage?

[free text answer]

- National abortion statistics show that women in more deprived circumstances are more likely to need to access abortion services. We also know from national statistics that they are more likely to rely on benefits, less likely to have access to private transport, more likely to work in jobs with poor benefits or zero-hour contracts where sick pay is minimal or non-existent, and less likely to be able to afford childcare. If women are required to attend clinics, more deprived women will be put in the most difficult position.
- Abortion providers report that women on lower incomes may often struggle to access clinics – asking providers to delay appointments until they are next paid so that they can afford to

travel. This delays their appointments and increases average gestation – increasing their risk of complications.

Question 10: Should the temporary measure enabling home use of both pills for EMA [select one of the below]

a) Become a permanent measure?

b) End immediately?

c) As set out in the current temporary approval, be time limited for 2 years or end when the temporary provisions of the Coronavirus Act 2020 expire, whichever is earlier?

d) Be extended for one year from the date on which the response to this consultation is published, to enable further data on home use of both pills for EMA and evidence on the temporary approval's impact on delivery of abortion services to be gathered?

e) Other [please provide details]?

Question 11: Have you any other comments you wish to make about whether to make home use of both pills for EMA a permanent measure?

[free text answer]

The option of both pills to be taken at home, and the use of telemedicine, should be a permanent measure. It is also important the choice is retained with abortion care pathways, and that women are able to choose between medical or surgical methods of abortion, and can choose between in-person clinic-based or remote care. Home-use should be part of a range of health care options abortion that centre the needs of women. Studies have shown that women highly value the choice of abortion procedure (medical or surgical), and home is not a safe or comfortable place for everyone. For abortion care to be high quality, accessible and patient-centred, the health system should include a range of options, which includes telemedicine abortion and clinic-based care, and both medical or surgical options.