DFC'S RESPONSE TO ENGLAND'S CONSULTATION

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

Abortion is a common and safe procedure: one in three women[1] of reproductive age will have an abortion, and when performed in line with best practice it is safer than childbirth[2].

Telemedicine services have been previously shown to be as safe as in-person abortion care: a systematic review from 2019 concluded that "rates of complete abortion, continuing pregnancy, hospitalization, and blood transfusion after abortion through [telemedicine under ten weeks gestation] were at similar levels to those reported after in-person abortion care in the published literature"[3]. For this reason, telemedicine as a new model of service provision has been a key campaigning message for Doctors for Choice UK and other organisations for many years.

A recent national cohort study compared, amongst other things, the safety of medical abortion before and after the introduction of telemedicine services; the study included 52,142 abortions (85% of all abortions provided in England and Wales during the study period) and found that there was "no difference in success rates" between abortions provided via telemedicine services and those provided in-person with routine ultrasound scanning, nor was there a difference in the prevalence of serious adverse events[4].

Abortion is a safe procedure, but it is safer the earlier it is performed[2] so a service model that enables women to access abortions earlier in their pregnancy will be providing safer care. Publically available data from the RCOG (which collates data from independent sector providers, who provide about 75% of abortions in the UK) show that the average gestation at the time of the abortion procedure has steadily and significantly reduced since new regulations allowed home-use of both abortion medications and service providers started to roll out their telemedicine services. The average gestation before the pandemic was 8.11 weeks, which has dropped to 6.70 weeks as of 8 June 2020.

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[1] RCOG, The Care of Women Requesting Induced Abortion (2011)
[2] RCOG, Best practice in comprehensive abortion care, v.2 (June 2015)
[3] Endler M, Lavelanet A, Cleeve A, Ganatra B, Gomperts R, Gemzell-Danielsson K. Telemedicine for medical abortion: a systematic review. BJOG 2019;126:1094–1102
[4] Aiken A, Lohr P, Lord J, Starling J. Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study. doi: https://doi.org/10.1101/2020.12.06.20244921

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

In 2019, NICE stated that improving access to abortion services was a key priority: their systematic review found that, amongst other things, remote services, community services, and reduced waiting times should improve the sustainability of and access to abortion services, most likely for those in vulnerable groups[5]. As a result, NICE guidelines recommend utilising telemedicine as a way of improving access.

Despite the presence of safe and legal services provided by the NHS and other independent providers, these services are not universally available; research has shown that some women can face multiple barriers in accessing abortion services[6]. These women however are likely to benefit from the increased flexibility and autonomy provided by telemedicine services. One good indicator of the accessibility of the new telemedicine model is the number of women accessing abortion through alternative (and illegal) sources, such as Women on Web. A recent analysis of the demand for self-managed abortion telemedicne services in eight European countries showed that in Great Britain there was an 88% decrease in the demand for such services during the Coronavirus pandemic; it was the only country to experience a decline, with others either experiencing no change in demand (two countries) or a huge increase in demand (five countries) for these alternative sources of abortion provision[7]. Retaining telemedicine services, with the support of NHS services and independent service providers, is therefore likely to reduce the number of women who feel the need to access these alternative (and, under current UK regulations, illegal) services.

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[5] Laura E O'Shea, James E Hawkins, Jonathan Lord, Mia Schmidt-Hansen, Elise Hasler, Sharon Cameron, Iain T Cameron, Access to and sustainability of abortion services: a systematic review and meta-analysis for the National Institute of Health and Care Excellence—new clinical guidelines for England, Human Reproduction Update, Volume 26, Issue 6, November-December 2020, Pages 886–903, https://doi.org/10.1093/humupd/dmaa026

[6] Aiken A, Guthrie K, Schellekens M, Trussell J, Gomperts R. Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain. Contraception 97(2) pp. 177-183. 2018.

[7] Aiken A, Starling J, Gomperts J, Scott JG, Aiken C. Demand for Self-Managed Online Telemedicine Abortion in Eight European Countries During the COVID-19 Pandemic: A Regression Discontinuity Analysis. https://doi.org/10.1101/2020.09.15.20195222

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

Abortion providers ask all those using telemedicine services if they feel able to talk confidently and privately, with data from MSI Reproductive Choices UK showing that 95.3% of respondents felt that they could talk privately (none reported that they could *not* report privately)[8]. Concerns are often raised about the potential impact of telemedicine on the ability of abortion providers to effecitvely safeguard vulnerable patients, but these have proved to be unfounded. It is noted by the British Society of Abortion Care Providers[9] that it is more common for men to control women's access to healthcare (including abortion) than it is for them to force a woman to have an abortion against her will. Abortion providers have robust processes in place to flag safeguarding concerns and investigate them; independent providers report the same rate of detection of safeguarding issues before and after the introduction of telemedicine, and it has been suggested that better privacy at home enables women and pregnant people to talk more freely.

[8] Porter C, Lord J, Church K. Early medical abortion using telemedicine - acceptability to patients. https://doi.org/10.1101/2020.11.11.20229377

[9] BSCAP Submission to the Health and Social Care Committee Inquiry Delivering Core NHS and Care Services during the Pandemic and Beyond (May 2020), page 7.

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.

Doctors for Choice UK members are unanimous in their support of telemedicine in abortion care. This is because it allows us to provide better quality care to women and pregnant people who need an abortion.

NICE recommends a waiting time of no more than one week between request and assessment and another week between assessment and procedure. Data from BPAS show that the waiting time for an abortion through their service was reduced by 50% to just two days[10]. Publicly available data from the RCOG (which collated data from independent sector providers, who provide about 75% of abortions in the UK) show that the average waiting time for an abortion has halved during the time of data collection, reducing to 4.5 days.

Other advantages include:

- More efficient clinics.
- Allows us to give additional time to clients with more complex needs attending clinics in person.
- Self-referral for telemedicine appointments means there is less pressure on sexual health and GP-services.

[10] BPAS (2020) Pills by Post: Telemedical Abortion at the British Pregnancy Advisory Service. Available at <https://www.bpas.org/media/3385/bpas-pills-by-post-service.pdf>

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

b) No

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?

As part of the process of gaining consent, healthcare providers must include information about the risks and benefits of a procedure in a way that is understandable to the patient. The information that forms part of the medical consultation is best decided by doctors and healthcare professionals and not the government.

Doctors for Choice UK would support any move to remove the arbitrary gestational limit of 10 weeks from the current temporary regulations and future permanent regulations.

There is evidence that women are accurate in reporting the date of their LMP, and that it is safe to use the date of the woman's last menstrual period (LMP) to determine eligibility for early medical abortions. Medical management of abortions is still effective at later gestations than currently allowed by regulations: there is evidence that a medical regimen is effective at 9-13 weeks' gestation[11], and at 13-20 weeks' gestation[12]; the overall success rate of self-managed abortions at more than 12-24 weeks' gestation is 93%[13], with an efficacy and safety profile similar to earlier gestations[14].

A recent large-scale analysis of abortion care provision before and after the regulatory changes shows that only 0.04% of abortions appeared to have been provided beyond 10 weeks; there abortions were "all completed at home without additional medical complications"[15].

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[11] Hamoda H, Ashok P, Flett G, Templeton A. Medical abortion at 9–13 weeks' gestation: a review of 1076 consecutive cases (2005). Contraception, 71(5) pp, 327-332.
[12] Haitham Hamoda, Premila W. Ashok, Gillian M.M. Flett, Allan Templeton, A randomized trial of mifepristone in combination with misoprostol administered sublingually or vaginally for medical abortion at 13–20 weeks gestation, Human Reproduction, Volume 20, Issue 8, August 2005, Pages 2348–2354, https://doi-org.knowledge.idm.oclc.org/10.1093/humrep/dei037
[13] Harris L, Grossman D. Complications of Unsafe and Self-Managed Abortion. N Engl J Med 2020; 382:1029-1040. DOI: 10.1056/NEJMra1908412
[14] Raymond E, et al. No-test medication abortion: A sample protocol for increasing access during a pandemic and beyond. Contraception 101 (2020) 361–366.
[15] Aiken A, Lohr P, Lord J, Starling J. Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study. doi: https://doi.org/10.1101/2020.12.06.20244921

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?

b) Yes, disadvantages

There is no clinical benefit to having a statutory blanket requirement for women to make at least one visit to a service: the evidence presented in this consultation response shows that a remote service is as safe and as effective as an in-person service. Reinstating a legal requirement for women to make at least one visit would therefore represent an unwarranted and politically-motivated interference that would disproportionately affect women from disadvantaged groups.

Similarly, there is no benefit in relation to safeguarding to having a statutory blanket requirement for women to make at least one visit to a service: abortion care providers are bound by law and professional guidance to act on any safeguarding concerns, and so everyone who access abortion services is asked if they feel safe at home, whether that is via telemedicine or during a clinic visit. Abortion providers have reported that better privacy at home enables women and pregnant people to talk more freely, and they report the same rate of detection of safeguarding issues before and after the introduction of telemedicine. Face-to-face appointments are still available for women who feel they need them and for those about whom providers have safeguarding concerns; making recent regulatory changes permanent would not change this.

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?

Age. Young women and girls are less likely to have access to means of private travel or the finance for public transport to access in-person services; so to remove the regulatory changes that allow remote access would have a negative and disproportionate effect on this age group.

Disability. Previous research has shown that women with disabilities face unique challenges in seeking reproductive healthcare, including issues with access to health facilities and clinics[16]; by offering a remote service, telemedicine is likely to ease access to abortion services for women who would otherwise face difficulties in engaging with services that require several visits to a clinic.

Race and religion/belief. 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.

[16] Engender (2018) Our Bodies, Our Rights: Identifying and removing barriers to disabled women's reproductive rights in Scotland. Available at < https://www.engender.org.uk/files/our-bodies,-our-rightsidentifying-and-removing-barriers-to-disabled-womens-reproductive-rights-in-scoltand.pdf>

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?

There are many hidden costs to accessing in-person abortion care services, most prohibitively child-care, organising time off work, and travel. In England and Wales there is a strong association between deprivation and abortion, with the rate in the most deprive decile (26.1 per 1000 women) being more than double the rate in the least deprived decile (12.20 per 1000 women)[17]; attempts to revoke temporary regulatory changes would therefore disproportionately affect women of lower socio-economic status. Expanding telemedicine services would clearly alleviate some of these financial burdens by allowing flexibility in accessing remote services and actually managing an abortion at home.

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https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/891405/abortion-statistics-commentary-2019.pdf

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]?

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