DFC UK response to Scottish government's consultation

What impact do you think that the current arrangements for early medical abortion at home (put in place due to COVID-19) have had on women accessing abortion services? Please answer with regards to the following criteria:

a) **Safety**

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.

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.

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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

Firstly, it is noted by the British Society of Abortion Care Providers[5] 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.

b) Accessibility and acceptability

POSITIVE IMPACT

Accessibility

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[6]. 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[7]. 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[8]. 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] 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.

[6] 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

[7] 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.

[8] 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

Acceptability

Data from MSI Reproductive Choices UK shows that overall 98.2% of those who responded to satisfaction surveys after accessing an abortion via telemedicine reported that their experience was either "very good" or "good"[9]. Other key points from their data:

- 95.3% felt that they could talk privately (none reported that they could *not* report privately)
- 99.3% felt that they have the opportunity to ask questions
- 92.4% felt they "definitely" had enough information to manage their own abortion, with a further 5.5% reporting they had "somewhat" enough
- 83.3% *would not* have preferred a face-to-face service
- 66.3% expressed a preference for a future telemedicine service if there were no COVID-19

Data from BPAS[10] shows that:

- Overall, 96.9% of respondents were either "very satisfied" or "satisfied" with a telemedicine service
- Most (78.4%) would opt for a telephone consultation, medical abortion with home use of mifepristone and misoprostol (77.8%), and receipt of medications by mail (68.9%).

It is clear, therefore, that patients report high levels of satisfaction with telemedicine services, as well as confidence that they have enough information to have abortions in their own homes and on their own terms. It should be noted, however, that there is a significant minority of women who would in future prefer to have at least some face-to-face interaction; this means that telemedicine services should be integrated into, and should not replace, existing in-person services.

c) Waiting times

POSITIVE IMPACT

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[11].

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

[10] Maurice M, Whitehouse K, Blaylock R, Chang J, Lohr P. Client satisfaction and experience of home use of mifepristone and misoprostol for medical abortion up to 10 weeks' gestation at British Pregnancy Advisory Service: a cross-sectional evaluation. https://authorea.com/doi/full/10.22541/au.160691768.87050587

[11] 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>

Publically 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.

2) What impact do you think that the current arrangements for early medical abortion at home (put in place due to COVID-19) have had for those involved in delivering abortion services? (For example, this could include impacts on workforce flexibility and service efficiency.)

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.

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's less pressure on sexual health and GP-services.
- Fewer clinic appointments improves our safety as well as the safety of our patients during the pandemic, including those who still need to attend in person.

3) What risks do you consider are associated with the current arrangements for early medical abortion at home (put in place due to COVID-19)? How could these risks be mitigated?

Abortion is a common and safe procedure; any clinical risks associated with the use of early medical abortion are best addressed by clinical guidelines and not by legislation. NICE made recommendations in 2019 (including the recommendation to utilise telemedicine technology to improve access), and the RCOG have published guidelines specific to abortion care during the pandemic[12].

One risk of the current arrangements is that they are temporary. Evidence shows that telemedicine services are safe and effective, that they improve access (most likely for those in vulnerable situations), and that they are acceptable to the vast majority of service user; so to ignore this evidence in a purely political pursuit of restricting access to abortion for the sake of it would represent a real risk to the health and wellbeing of women and pregnant people across Scotland. To mitigate this risk, regulations should allow telemedicine to become a permanent feature of abortion care provision.

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[12] RCOG (July 2020). Coronavirus (COVID-19) infection and abortion care.

4) Do you have any views on the potential impacts of continuing the current arrangements for early medical abortion at home (put in place due to COVID-19) on equalities groups (the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation)?

YES

Everyone should be able to access safe and effective abortion care, and so the experiences and realities of diverse groups of women and pregnant people must inform the design and delivery of services.

There are often concerns raised about the potential impact of telemedicine on the ability of abortion care providers to effectively safeguard vulnerableand pregnant women, but these concerns have proved to be unfounded. Indeed, the introduction of telemedicine is likely to have helped vulnerable women, such as those in coercive and controlling relationships. Previous regulations necessitated numerous trips to a clinic, which would have proved very difficult for those in abusive relationships; but telemedicine has enabled those same women to more easily access services remotely and privately, revoking these temporary regulatory changes will put women at risk of escalating abuse.

Previous research has shown that women with disabilities face unique challenges in seeking reproductive healthcare in Scotland, including issues with access to health facilities and clinics[13]; 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.

Another group of concern has been single parents: members of the British Society of Abortion Care Providers (BSACP) have reported their concern over how women with children might find it challenging to organise and pay for childcare for when they are required to go to an abortion clinic[14]; offering a telemedicine service, however, would lift the burden of orgnanising and financing childcare by giving women the option of accessing abortion care without leaving their homes.

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[13] 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>

[14] BSACP (2020) Submission to the Health and Social Care Committee Inquiry. Available at https://bsacp.org.uk/wp-content/uploads/2020/05/Submission-to-Health-Social-Care-Committee-on-Coronavirus-080520.pdf

5) Do you have any views on potential impacts of continuing the current arrangements for early medical abortion at home (put in place due to COVID-19) on socio-economic equality?

YES

There are many hidden costs to accessing in-person abortion care services, most prohibitively child-care, organising time off work, and travel. In Scotland there is a strong association between deprivation and abortion, with the rate of abortion in 2019 being 2.1 times higher in the most deprived areas compared to the least deprived areas; attempts to revoke temporary regulatory changes would therefore disproportionately affect women of lower socio-economic status[15]. 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.

[15] Public Health Scotland (2020) Termination of pregnancy statistics, available at https://beta.isdscotland.org/find-publications-and-data/population-health/sexual-health/termination-of-pregnancy-statistics/

6) Do you have any views on potential impacts of continuing the current arrangements for early medical abortion at home (put in place due to COVID-19) on women living in rural or island communities?

YES

Women and pregnant people living in rural and island communities will have to travel longer distances to access in-person appointments, which will increase the financial burden of accessing care and, for those living in close-knit communities, will make it more challenging to explain protracted absences. Expanding telemedicine services would clearly alleviate some of these challenges by allowing flexibility in accessing remote services and the postage of abortion pills to rural communities.

7) How should early medical abortion be provided in future, when COVID-19 is no longer a significant risk? [select one of the options below]

a) Current arrangements (put in place due to COVID-19) should continue - in other words, allowing women to proceed without an in person appointment and take mifepristone at home, where this is clinically appropriate.

Rescinding Telemedicine would put the healthcare professionals who provide abortions in Scotland in a difficult ethical and professional position, forcing them to give treatment we know is less patient-centred, less effective, less acceptable and a little less safe as well. There is no clinical reason to stop telemedcine for abortion or professional or ethical justification. The only reason to stop it would be to punish women for getting pregnant in the first place by making abortion more difficult to access.