DFCUK'S RESPONSE TO WELSH CONSULTATION

1) **Do you consider that the temporary approval has had a positive impact on the provision of abortion services for women accessing these services with particular regard to safety, accessibility and convenience of services? Please provide your reasons.**

Safety

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.

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

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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

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.

Conveniences of services

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”[8]. 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

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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

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

Data from BPAS[9] 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.

[9] 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

2) **Do you consider that the temporary measure has had a positive impact on the provision of abortion services for those involved with service delivery? This might include greater workforce flexibility, efficiency of service delivery, value for money etc. Please provide your reasons.**

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>

3) What risks do you consider are associated with the temporary measure? If you consider that there are risks, can 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[11].

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.

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

4) **In your experience, have other NHS Wales services been affected by the temporary approval? If so, which?**

5) **Outside of the Covid-19 pandemic, do you consider there are benefits 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? Please outline those benefits.**

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.

6) **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 on people with a disability or on people from different ethnic or religious backgrounds?**

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[12]; 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.

[12] 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>

7) **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 people from more economically disadvantaged areas 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)[13]; 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

8) Should the temporary measure enabling home use of both pills for EMA:

1. Become a permanent measure?

2. Remain unaffected (i.e. be time limited for two years and end two years after the Coronavirus Act came into force (25 March 2022), or end on the day on which the temporary provision of the Coronavirus Act 2020 expire, whichever is earlier).

3. Other [please provide details]?