

FSRH Response to the Department of Health and Social Care consultation on the home use of both pills for early medical abortion up to 10 weeks gestation in England

25th Feb 2021

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

1. The [Faculty of Sexual and Reproductive Healthcare \(FSRH\)](#) welcomes the opportunity to respond to the Department of Health and Social Care's consultation on the home use of both pills for telemedicine abortion. FSRH supports the proposal to make permanent the current temporary approval allowing for home use of both pills, mifepristone and misoprostol, for Early Medical Abortion (EMA) for all eligible women in England, up to 10 weeks' gestation.
2. FSRH is the largest UK multidisciplinary professional membership organisation representing more than 15,000 doctors and nurses working at the frontline of Sexual and Reproductive Health (SRH) care delivery, including abortion care in England. Our goal is to ensure that the population can access high-quality and holistic SRH care across the life course, and that essential SRH services remain available to the population during and after the COVID-19 pandemic.
3. In this consultation response, we present the findings of recent empirical studies on the home use of abortion pills, as well as evidence from our members. We draw in particular from the recently launched national cohort study by Aiken et al of data from the following independent abortion care providers: British Pregnancy Advisory Service (BPAS), MSI Reproductive Choices and the National Unplanned Pregnancy Advice Service (NUPAS).¹ The study sample represents 85% of the total number of medical abortions performed in England and Wales during the study period. The study sample includes all patients who accessed EMA from these three providers during the two months before and two months after the service model changed. A comparison was made between 22,158 women accessing EMA between 1 January and 1 March 2020 (the traditional cohort involving face-to-face consultations) and 29,984 accessing EMA between 6 April and 30 June 2020 (the telemedicine cohort involving a telephone consultation and home use of both abortion pills). In the latter cohort, 61% of patients were treated entirely by telemedicine. This study

¹ Aiken, Lohr, Lord, Ghosh, & Starling, 2020. [Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study.](#)

is not only scientifically robust but also reports on the real-world experience of how the entire service was delivered.

4. Evidence demonstrates that the remote care pathway facilitated by the temporary approval order has been safe and effective for women, with no added risk of negative outcomes associated with the home use of both pills. Abortion is a clinically safe procedure, regardless of the gestation length when performed. Aiken et al found that the telemedicine group carried no added prevalence of serious adverse events compared to the traditional group, where mifepristone was administered by a healthcare professional following an in-person consultation.
5. Abortions carry a reduced risk of complications the earlier in the pregnancy they are performed. Aiken et al found that average waiting times were 4.2 days shorter in the telemedicine cohort, and that 40% of abortions were provided at under 6 weeks' gestation compared to 25% in the traditional cohort.
6. Aiken et al found that identification of potential complications, including ectopic pregnancies, is as effective in telemedicine pathways as in traditional pathways. The incidence of ectopic pregnancy was equivalent in both cohorts, with no significant difference in the proportions being treated after abortion.
7. A post-abortion survey of telemedicine patients by MSI Reproductive Choices found that 87% of women receiving care had no concerns about the safety of taking both abortion pills by themselves.² Those with concerns reported a general anxiety around the procedure, including whether it would work, what level of bleeding and pain to expect, and how they would cope if they experienced complications. These concerns do not relate specifically to the at-home administration of mifepristone and would apply equally to the traditional EMA pathway available to women before the introduction of telemedicine for abortion. Moreover, these concerns were often alleviated through further telephone support.
8. This measure also protects patients and clinic staff from unnecessary exposure to COVID-19 infection. A British Pregnancy Advisory Service (BPAS) survey, included in Aiken et al's study, found that 2.8% of women choosing to receive both abortion pills by post explicitly mentioned self-isolating or shielding at the time of their EMA. The approval order has enabled these women to access critical healthcare while reducing exposure to the COVID-19, as well as minimising related anxiety.

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

² Erlank, Lord, & Church, 2020. [Early medical abortion using telemedicine – acceptability to patients.](#)

- b) Yes, it has had a negative impact
- c) It has not had an impact
- d) I don't know

1. The temporary measure has had a positive impact by making abortion care more accessible and convenient. Evidence demonstrates that the remote care pathway facilitated by the temporary approval order has been safe, accessible and acceptable for women, with no added risk of negative outcomes associated with home use of both pills. It has enabled women and girls to access abortion care from the safety and comfort of their own home, without unnecessary exposure to the risk of infection from COVID-19.
2. The pre-pandemic requirement for attendance at a clinic or hospital created barriers in access to care by requiring women to travel, and often to arrange childcare or absence from work. Qualitative studies show that reasons for travel to access abortion care are not driven by a preference to see a healthcare professional face-to-face, but are instead necessitated by a number of accessibility barriers including the lack of local services or legal restrictions.³ In a systematic review of telemedicine for abortion care, NICE noted that telemedicine is likely to improve access, especially for vulnerable groups.⁴
3. The new telemedicine pathway allows women to begin the abortion at a time which is convenient for them – for example, over a weekend. This means it is easier for women to plan for the procedure and to reduce disruption to their lives which may otherwise be caused by the procedure. A further survey by BPAS of women who had undergone the telemedicine pathway found that women valued the service because it provided greater flexibility over the timing of the procedure.
4. Data show overwhelmingly that the home use of abortion pills is preferred by women. A survey by MSI Reproductive Choices to assess patient experience² found that:
 - **83.3% would not have preferred a face-to-face pathway**
 - 92.4% reported they had enough information to manage the process at home
 - 87.4% had no concerns about taking the medication by themselves
 - 98.2% rated their experience as good/very good
 - 95.3% patients felt able to talk privately
 - 99.3% had the opportunity to ask any questions
5. A similar survey by the British Pregnancy Advisory Service, included in Aiken et al's study, found that:
 - 96% were satisfied or very satisfied with the service
 - 80% would choose to receive remote care even if the option of face-to-face care were available

³ Heller, Purcell, Mackay, Caird, & Cameron, 2016. [Barriers to accessing termination of pregnancy in a remote and rural setting: a qualitative study.](#)

⁴ NICE, 2019. [Abortion care guideline evidence review.](#)

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

1. The pre-pandemic requirement for in-person attendance posed specific barriers to women at risk of domestic abuse or reproductive coercion, which the remote care pathway facilitated by the temporary approval order has helped to alleviate. Women living with abusive partners or who may be worried about abortion-related stigma face difficulty accessing in-person services discreetly.
2. In 2020, FSRH conducted a members' survey that received over 1100 responses. Our members reported that women who may previously have felt unable to discuss intimate or distressing details in person can talk more openly via telephone. MSI Reproductive Choices has reported an increase in safeguarding disclosures during the pandemic, suggesting that women feel more comfortable disclosing safeguarding issues during remote consultations.⁵
3. In the MSI Reproductive Choices patient survey, 95.3% patients said they felt able to talk privately in their own home.²

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

1. The temporary measure has been positively regarded by abortion care providers and has had a positive impact on the healthcare service. Remote consultations save time, which enables healthcare providers to see more patients and reduce waiting times. Telemedicine also allows healthcare providers to work more flexibly, for example if they need to work from home when shielding. Healthcare providers can continue to provide care safely, without the risk of contracting COVID-19 in a clinic setting.

⁵ MSI Reproductive Choices, 2020. [Written evidence submitted by Marie Stopes UK \(MRS0321\)](#).

2. An FSRH member and abortion care lead said “We have been trying nationally for years to get our waiting times down to the RCOG recommended limit of five days. Since these temporary legal changes this has finally been achieved. The waiting times have reduced from a couple of weeks to a couple of days. The average gestation at abortion has also reduced, from 8 weeks to 6 weeks. We manage more patients outside the hospital, and we manage less patients surgically than before. The complication rate has not increased. The patients are very happy with this new way of working. It involved less travel and less time off work for our patients. The risk of COVID transmission, as well as other infections, has obviously been reduced. This will need to continue. I very much hope that these legal changes can be made permanent.”
3. A further FSRH member and abortion service lead said: “The implementation of the temporary approval has had an enormous impact both on the local health economy and on the improvement of care for women. Women have a shorter wait to their appointment, are seen at an earlier gestation, experience far shorter waits in clinic, have improved patient experience and there have been fewer failed procedures or complications.”
4. A further FSRH member and abortion service lead said: “The data from the Aiken et al study shows that telemedicine has enabled thousands of women to access safer abortion care during a time when travel and face-to-face consultations needed to be severely restricted due to risk of COVID-19 infection. I truly hope the option for telemedicine will continue beyond the restrictions because in my clinic we have experienced first-hand the benefits of telemedicine for abortion care. Many of our patients have been able to discuss their options and obtain treatment in a timely manner following a simple remote consultation. Patients really value and appreciate that they are getting high-quality care without the need to attend a clinic (unless there is a genuine need for in-person investigation or care). Allowing home use of the first abortion pill, mifepristone, for early medical abortion enhances women’s options - and makes this safe and effective healthcare treatment easier to obtain.”
5. The continued provision of telemedicine abortion services would result in substantial savings to the NHS. The National Institute for Health and Care Excellence (NICE) found that for every day’s reduction in waiting time, the NHS in England would save £1.6m per year owing to reduced complications and fewer needing to opt for a surgical abortion.⁶ Extrapolating from the estimates of this guideline, about £6.7 million per year is being saved in England under the temporary measures.

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

- a) Yes
- b) No
- c) I don’t know

⁶ NICE, 2019. [Abortion care](#).

1. Our members report that the temporary approval of telemedicine abortion services has reduced the pressure on early pregnancy and gynaecology services, as women are treated at earlier gestation and are thus less likely to experience complications. Without the need for clinically unnecessary ultrasound scans, waiting times and consultation times have been reduced.

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?

1. Abortion providers include information around potential risks in discussion with patients, and scans are always offered if the patient is not confident of the date of their last missed period (LMP). Doctors and nurses should be supported to act in good conscience and in the best interests of the patient. It is the FSRH's position that doctors and nurses are the best judges of what they need to discuss with their patients, and that it is unnecessary to impose any additional legal guidance on this matter.
2. FSRH has recently published guidance for the provision of abortion care services during the COVID-19 pandemic, together with the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of Midwives and the British Society of Abortion Care Providers (BSACP).⁷ This guideline outlines an evidence-based approach to delivering best practice abortion care remotely, using well established models that are already widely used.
3. Most women can determine the gestational age of their pregnancy with reasonable accuracy by LMP alone. Aiken et al's national cohort study of telemedicine for abortion found just 11 cases out of 29,984 (0.04%) in the telemedicine cohort in which the gestational age after abortion was reported as being greater than the expected 10 weeks. In all these cases, the medical abortion was completed at home without additional complications.
4. In Scotland, the home use of both abortion pills is allowed until 12 weeks' gestation. In a study of 663 women in Scotland who took both abortion pills at home and did not receive an ultrasound, no patients were inadvertently treated beyond 12 weeks' gestation. The study showed high rates of complete abortion, low rates of complications and low rates of unscheduled contact with healthcare services. The authors concluded that "telemedicine abortion without routine ultrasound is safe, and has high efficacy and high acceptability among women".⁸

⁷ Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Faculty of Sexual and Reproductive Healthcare and the British Society of Abortion Care Providers, 2020. [Coronavirus \(COVID-19\) infection and abortion care.](#)

⁸ Wright, Johnstone, McCabe, Evans, & Cameron, 2021. [Telemedicine medical abortion at home under 12 weeks' gestation: a prospective observational cohort study during the COVID-19 pandemic.](#)

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

Safeguarding

1. There are no benefits in relation to safeguarding or to women's safety in requiring them to make at least one visit to an abortion service. Any requirement for travel to a clinic imposes barriers to care for women, especially for women in marginalised groups. These requirements remove the convenience for all women to choose when to begin their abortion, which has severe implications for specific groups, e.g. women who work in inflexible jobs without paid sick leave, women solely responsible for the care of young children, women in coercive relationships, or women experiencing domestic violence.
2. Safeguarding processes have been enhanced rather than damaged by the introduction of the telemedicine pathway facilitated by the temporary approval order. Healthcare professionals have reported that women feel more comfortable talking and making safeguarding disclosures while speaking on the telephone rather than during a face-to-face consultation. This is supported by the rise in safeguarding disclosures since the introduction of the remote care pathway facilitated by the approval order. While some safeguarding concerns may still warrant a face-to-face consultation, it is likely that any requirement to attend clinic as part of the care pathway would reverse progress in this area, creating barriers to safeguarding disclosures for some vulnerable women.

Safety

3. While abortion is a clinically extremely safe procedure, and in all cases safer than childbirth, the risk of complications is more marginal the earlier the procedure is carried out. Any requirement resulting in increased waiting times marginally increases the risk of complications by delaying access to abortion care. A requirement to attend a clinic is therefore not in the best interests of all women, though women should retain the option to access face-to-face care after the pandemic if that is their preference.
4. Waiting times and the average length of gestation at the time of abortion have both fallen substantially since the temporary approval allowing for home use of both pills was introduced. Aiken et al found that average waiting times were 4.2 days shorter in the telemedicine cohort, and 40% were provided at under 6 weeks' gestation compared to 25% in the traditional cohort.
5. Routine ultrasound scanning is not clinically necessary unless women have risk factors for or symptoms suggestive of an ectopic pregnancy. Aiken et al's study found no statistically significant difference between the telemedicine cohort and the traditional pathway cohort

in the prevalence of serious adverse events, and the incidence of ectopic pregnancy was equivalent in both cohorts. This suggests that screening processes for potential contraindications are as effective in the telemedicine pathway as the traditional pathway.

6. Women with complex care needs which necessitate face-to-face consultations and scans will continue to access them. Aiken et al outline that routine scanning in symptom-free, pregnant women without risk factors may aid detection of some cases but falsely reassure others that a pregnancy is intrauterine. The absolute incidence of ectopic pregnancy in those undergoing abortion is ten times lower than that in women who wish to continue with their pregnancy. Pregnant women who wish to continue their pregnancy are not seen in person and scanned, unless they have symptoms of an ectopic pregnancy. There is therefore no clinical justification for maintaining an inconsistency in care between those continuing their pregnancy and those choosing EMA.
7. Evidence collected during the COVID-19 pandemic clearly demonstrates that women have the capacity to make the decision to take mifepristone, the first abortion pill, by themselves in the privacy of their homes. Taking both mifepristone and misoprostol at home has been routine practice across the world for many years and has an excellent safety record. This approach is also preferred by women. A study by MSI Reproductive Choices UK² found that 92.4% of women reported they had enough information to manage the process at home, and 87.4% had no concerns about taking the medication by themselves (concerns highlighted were general concerns about the effectiveness of the regimen).

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?

1. In a systematic review of telemedicine for abortion care, NICE noted that telemedicine is likely to improve access, especially for vulnerable groups.⁹ We outline a number of groups who particularly benefit from access to telemedicine services.
2. **Young women.** Young people are disproportionately likely to lack the ability to travel for care, and (if they live with parents) may be less able to leave their household to attend a clinic without raising questions. The approval order facilitating a telemedicine pathway for abortion has increased the accessibility of abortion services and enabled young women to better maintain privacy.
3. **Black, Asian, and Minority Ethnic (BAME) women and women from religious communities.** Members of all communities across the UK access abortion services. However, people from BAME communities and/or religious communities may encounter specific social obstacles, including stigma, if abortion is a controversial issue in their religion or culture. The option to access care at home and without travelling to a clinic will improve ease of access for such women, allowing them to maintain privacy and discretion.

⁹ NICE, 2019. [Abortion care guideline evidence review](#).

4. **Women with disabilities.** Women with disabilities often face barriers attending services in person, particularly in cases where they do not have their own means of transport or require an escort to attend a clinic. By delivering abortion medication by post, telemedicine makes abortion more accessible for many disabled women. Without telemedicine, there is a real risk that these women are forced to turn to illegal online options because they cannot access care within the formal healthcare system.
5. **Women in abusive relationships or who may be subject to reproductive coercion.** Those in abusive relationships may be unable to travel to a clinic due to the need to conceal their pregnancy from an abuser. The option to access care at home and without travelling to a clinic will improve ease of access for these individuals, allowing them to maintain privacy and discretion.
6. Anti-abortion groups often target those accessing an abortion clinic in person. While it can be distressing for anyone to receive this type of harassment, it can be disproportionately distressing for people who are already marginalised by a protected characteristic, such as people of colour, religious people, teenagers, trans or non-binary people, disabled people and people with mental health problems. Many people accessing abortion have experienced rape, abuse or assault. Harassment outside clinics can be particularly distressing for these individuals. Telemedicine allows people to avoid this harassment.

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?

1. There are significant socioeconomic and geographical disparities in abortion rates across England and Wales, with women from the lowest decile on the Index of Multiple Deprivation (IMD) twice as likely as women from the highest decile to require an abortion.¹⁰ Women from more deprived backgrounds are also more likely to lack access to a reliable form of transport, to be working inflexible hours or for a job that does not offer sick pay, and to lack access to childcare services.
2. There are therefore significant and demonstrable benefits associated with allowing women from deprived socioeconomic backgrounds to access abortion care remotely. The removal of the requirement to take mifepristone at an in-clinic appointment removes the need for travel and allows women to begin their abortion at a convenient time, for example to fit with a shift pattern which they may be unable to change. This improves accessibility and ameliorates the likelihood of financial penalties which might otherwise be associated with accessing abortion.
3. In England, over 20% of the population live in rural areas. Providing access to health care services is a particular challenge for many areas with dispersed populations. Women living in rural areas face particular barriers accessing abortion care, including the impact of long

¹⁰ Department of Health and Social Care, 2019. [Abortion statistics, England and Wales](#)

travel times as well as potential stigma from local healthcare providers.³ Remote provision of abortion care can enable women in rural areas to access abortion care safely and accessibly.

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

- a) **Become a permanent measure? Yes**
- 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]?

The temporary measure enabling home use of both pills for EMA should become a permanent measure (option a).

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?

The Faculty of Sexual and Reproductive Healthcare fully support the proposal to make the home use of both pills for EMA a permanent measure. Evidence demonstrates that the remote care pathway facilitated by the temporary approval order has been safe and effective for women, with no added risk of negative outcomes associated with the home use of both pills. Removing the requirement to attend an abortion clinic in person reduces waiting times for abortion care, reduces risk of complications, saves time for clinicians, and saves costs of delivering care for the NHS. Allowing the home use of abortion pills improves access to care, especially for vulnerable women. Abortion care is an essential part of healthcare. Making this measure permanent is a significant step towards ensuring equitable access to this vital service.