

FSRH Response to the Welsh Government consultation on Termination of Pregnancy arrangements in Wales

23rd February 2021

Question 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?

1. The [Faculty of Sexual and Reproductive Healthcare \(FSRH\)](#) welcomes the opportunity to respond to the Welsh Government's consultation on termination of pregnancy arrangements in Wales. 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 Healthcare (SRH) care delivery, including abortion care in Wales. Our goal is to ensure that the population can access high-quality and holistic SRH services across the life course, and that essential SRH services remain available to the population during and after the COVID-19 pandemic.
2. 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 Wales, up to 9 weeks and 6 days gestation. Our members report that this measure has had an overwhelmingly positive impact on the provision of abortion services for women accessing these services.
3. 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.
4. In this consultation response, we present the findings 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 is not only scientifically robust but also reports on the real-world experience of how the entire service was delivered.

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

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 EMA 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 EMA pathway available to women before the introduction of telemedicine for abortion. Moreover, these concerns were often alleviated through further telephone support.
8. In a systematic review of telemedicine for abortion care, the National Institute for Health and Care Excellence (NICE) noted that telemedicine is likely to improve access, especially for vulnerable groups.³ Many women face barriers in attending face-to-face services, e.g. due to lack of transport arrangements, disability, child-care responsibilities, or abusive relationships. Remote access to abortion services is vital in ensuring that these women can access care.
9. 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.
10. 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

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

³ NICE, 2019. [Abortion care guideline evidence review.](#)

11. 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

Question 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.

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.
2. An FSRH member and abortion care lead in Wales said "From the perspective of my Health Board and Wales generally these temporary changes have revolutionised abortion care in Wales. I lead the abortion services in Swansea Bay Health Board. 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 in Wales 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. 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.⁴

⁴ NICE, 2019. [Abortion care](#).

Question 3: What risks do you consider are associated with the temporary measure? If you consider that there are risks, can these risks be mitigated?

1. We do not consider that there are any additional risks associated with the temporary measure. Of the potential risks that have been raised, none are supported by evidence. These potential risks are a) uncertain gestational age due to lack of routine ultrasound scanning, b) late diagnosis of an ectopic pregnancy, c) difficulty in perception of non-verbal cues relevant to an unstable decision about abortion and to safeguarding issues and d) committing to initiation of the abortion process and taking the medicines away from medical supervision.
2. Regarding a), 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. In a further 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 the gestational limit for medical abortion. The authors concluded that "telemedicine abortion without routine ultrasound is safe, and has high efficacy and high acceptability among women".⁵
3. Regarding b), 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. 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.
4. Regarding c), the experience of FSRH members is that women can talk more freely and openly when consulting over the phone than in a clinic. Many people are intimidated by medical consultations and, with abortion care being so intensely personal and private, face-to-face discussions can be perceived as threatening. Many women expect to be judged given the stigma attached to abortion care, an expectation reinforced by the frequent protests that occur outside abortion clinics. In contrast, people are used to talking over the phone and when consultations are conducted from the privacy and safety of their

⁵ 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.](#)

own home, they are more likely to be open and honest, rather than feeling obliged to offer answers they perceive to be expected of them. This impression is borne out by consultations often taking longer over the phone – as the patients simply talk more – and that rates of identification of safeguarding issues have increased.

5. Regarding d), 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 UK 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).
6. Finally, abortion providers already include information around potential risks in discussion with clients, and scans are always offered if the client is not confident of the date of their last missed period. 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.

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

1. Our members based in Wales 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 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 these benefits.

1. There are no benefits in relation to safeguarding or to women's safety in requiring them to make at least one visit to a 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, or women solely responsible for the care of young children.
2. Safeguarding processes have been enhanced rather than damaged by the introduction of the telemedicine pathway facilitated by the temporary approval order. 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.⁶ 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.

3. A requirement to attend a clinic to receive abortion care increases waiting times and the average length of gestation at the time of abortion, both of which have 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.
4. 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.

Question 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?

1. In a systematic review of telemedicine for abortion care, NICE noted that telemedicine is likely to improve access, especially for vulnerable groups.⁷ 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 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.

⁶ MSI Reproductive Choices, 2020. [Written evidence submitted by Marie Stopes UK \(MRS0321\).](#) /

⁷ 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-choice 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. Anti-choice harassment outside clinics can be particularly distressing for these individuals. Telemedicine allows people to avoid this harassment.

Question 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?

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.⁸ 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 Wales, over 35% of the population live in rural areas. Providing access to health care services is a particular challenge for many areas with dispersed populations. A study by

⁸ Department of Health and Social Care, 2019. [Abortion statistics, England and Wales](#)

Heller et al⁹ found that women living in rural areas face particular barriers accessing abortion care, including the impact of long travel times as well as potential stigma from local healthcare providers. Remote provision of abortion care can enable women in rural areas to access abortion care safely and accessibly.

Question 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]?

1. The temporary home use of both abortion pills for EMA should become a permanent measure.

⁹ Heller, Purcell, Mackay, Caird, & Cameron, 2016. [Barriers to accessing termination of pregnancy in a remote and rural setting: a qualitative study.](#)