DEPARTMENT OF HEALTH AND SOCIAL CARE CONSULTATION: HOME USE OF BOTH PILLS FOR EARLY MEDICAL ABORTION UP TO 10 WEEKS GESTATION

Response from Humanists UK, February, 2021

ABOUT HUMANISTS UK

At Humanists UK, we want a tolerant world where rational thinking and kindness prevail. We work to support lasting change for a better society, championing ideas for the one life we have. Our work helps people be happier and more fulfilled, and by bringing non-religious people together we help them develop their own views and an understanding of the world around them. Founded in 1896, we are trusted to promote humanism by 100,000 members and supporters and over 100 members of the All-Party Parliamentary Humanist Group.

We campaign in favour of women's sexual and reproductive rights, in particular with respect to abortion. Our position on abortion is 'pro-choice'. We are a member of the steering group of Voice for Choice, the coalition of UK pro-choice groups. We also work with and support Alliance for Choice in Northern Ireland, as well as other pro-choice groups across the UK such as BPAS, Abortion Rights, Brook, and the Abortion Support Network.

EXECUTIVE SUMMARY

- In March 2020, the Government changed abortion regulations to allow women and girls in England to administer the medication needed to perform an early medical abortion (EMA) within their own home without an in-person appointment, known as telemedicine. By early medical abortion, this means up to the tenth week of gestation. This measure was taken to ensure that women could continue to receive care during the Coronavirus pandemic when abortion clinics were closed, and people advised not to travel for risk of infection. Similar measures were also introduced in Scotland and Wales.
- Not only has telemedicine been successful in ensuring continuity of care and reducing the risk of transmission of the virus, but significantly, it has also made the procedure safer and more accessible for women and girls, who are accessing services earlier in their pregnancies and in difficult circumstances which would have prevented them from attending a clinic. Overall, abortion is safer and more accessible because of this change.
- Based on this evidence and the advice of relevant medical bodies, including the Royal College of Obstetricians and Gynaecologists, we support the continuation of telemedicine after the period of the Coronavirus pandemic.

RESPONSE TO CONSULTATION QUESTIONS

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?

Yes, it has had a positive impact.

Telemedicine (as introduced in 2020) is safer for women and girls than other forms of abortion. Abortions have been performed legally in England for over 50 years and have a very high safety rate. One in three women will access abortion care during their life. For example, in 2019, there were

207,384 abortions performed in England and Wales with complications reported in 337 cases (1.6 per 1,000 abortions or 0.2%).[1] A study carried out by the University of Texas, published in the *British Medical Journal* in May 2017, found that in 95% of cases, women in Northern Ireland and the Republic of Ireland who used online-purchased abortion pills safely ended their pregnancies and did not require medical attention, and none of those who did require medical attention had any serious complications.[2] The study looked at data from 1,000 women between 2010 and 2012, who were less than ten weeks pregnant and had used the drugs misoprostol and mifepristone, both of which are used in abortions provided by the NHS. This evidence suggests that overall taking these pills at home is effective and safe and with only a slight increase in complication rate compared to NHS abortions. In 2017, most abortions were illegal in Northern Ireland and the purchasing of these pills online was a crime.

Moreover, the earlier an abortion is performed the less likely there are to be complications and therefore the safer it is. 40% of abortions since the change in regulations have been performed before six weeks, compared to only 25% beforehand.[3] Furthermore, 'between January to June 2020 (after telemedicine was introduced), 86% of abortions were performed at under 10 weeks. This compares with 81% in January to June 2019, an increase of 5 percentage points.' [4]

It is because a medical abortion is less invasive it is a safer procedure than surgical abortions which are usually carried out on later pregnancies. Between January to June 2020, medical abortions accounted for 82% of abortions.[5] This compares with 72% over the same period in 2019.[6] The majority (96%) of medical abortions in the first six months of 2020 were performed at under 10 weeks, similar to the proportion in the first six months of 2019 (95%).[7] Further, in March 2020, 78% of abortions were medical and 22% were surgical, whilst in April 2020, this changed to 88% of abortions being medical and 12% being surgical.[8]

Abortion providers are also reporting a corresponding drop in the number of complications. For example, between April and July 2020 complications for EMA declined compared to the same period in 2019, according to data provided by BPAS, the largest provider of abortion services in

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[1] Department of Health and Social Care, *Abortion Statistics, England and Wales: 2019.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/891405/abortion-statistics-commentary-2019.pdf

[2] Aiken, Abigail, *et al.* 'Self reported outcomes and adverse events after medical abortion through online telemedicine: population based study in the Republic of Ireland and Northern Ireland,' *BMJ* 2017; 357 https://www.bmj.com/content/357/bmj.j2011

[3] Aiken, Abigail, et al. 'Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study' December 2020 [Awaiting publication] doi: *https://doi.org/10.1101/2020.12.06.20244921*

[4] Department of Health and Social Care, *Abortion statistics for England and Wales during the COVID-19 pandemic.* December 2020. *https://www.gov.uk/government/publications/abortion-statistics-during-the-coronavirus-pandemic-january-to-june-2020/abortion-statistics-for-england-and-wales-during-the-covid-19-pandemic*

[5] *Ibid*

[6] *Ibid*

[7] *Ibid*

[8] *Ibid*

England, and the risk of major complication fell significantly from 0.09% to 0.03%.[9] The risk of continuing pregnancy after abortion fell by three-quarters to 0.28%, down from 1.12%.[10] This suggests that telemedicine not only has increased the safety of abortions during the pandemic by removing the need for women to travel to clinics but also inherently increased the safety of the procedure itself. It is easier for women and girls to book tele-appointments as they did not have to wait for in-person availability and could fit this around other commitments, so overall were able to end their pregnancy earlier. Additionally, being able to take the first pill at home rather than at a clinic meant that women were able to better manage the procedure, and this is likely to explain the drop in the rate of failed procedures.

The evidence that telemedicine is safer is overwhelming. It would seem illogical, given the above proven benefits of telemedicine, to return to mandated face-to-face clinic appointments after the period of the pandemic.

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?
Yes, it has had a positive impact.

Before the change in regulation, there were many barriers to women accessing services due to the requirement to attend a clinic. This included prohibitive travel costs or distance, childcare responsibilities, taking time away from work or home, domestic abuse, difficulties in being able to travel and arrange appointments discreetly, and the need to be accompanied by a friend, partner, or parent in the case of girls. All of these factors contributed to a lack of access to services.

There is already evidence that home use has improved accessibility. Before the pandemic, home use of the second pill misoprostol was permitted under law change in 2019. The *BMJ* published evidence suggesting that requiring only one visit to a clinic rather than two had already been successful in improving access. However, some of the above problems are still prevalent and disproportionately disadvantage women on low incomes and in vulnerable domestic settings.[11]

By enabling telemedicine in 2020, the evidence shows that there was an increase in service delivery even during the height of the first wave of the pandemic. The mean waiting times were 4.2 days shorter for women and girls using telemedicine than those attending clinics.[12] Acceptability among service users was extremely high with 96% of women and girls reporting they were satisfied with the service and 80% reported a future preference for telemedicine and none reported that

[9] BPAS, 'Pills By Post: English Government's public consultation on continue home use of both pills for early medical abortion response guide' December 2020. https://www.bpas.org/media/3417/england-ema-consultation-template-response-december-20.pdf
[10] *Ibid*
[11] Lord, J, *et al* 'Early medical abortion: best practice now lawful in Scotland and Wales but not available to women in England' *BMJ Sexual & Reproductive Health* 2018; 44:155-158. https://srh.bmj.com/content/44/3/155
[12] Aiken, Abigail, et al. 'Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study' December 2020 [Awaiting publication] doi: https://doi.org/10.1101/2020.12.06.20244921

they were unable to consult in private using teleconsultation.[13] The increase in procedures in March, April, and May 2020 compared to preceding years strongly suggest that abortion services were more readily accessible and that women and girls have benefitted from this change.

> 'Between January to June 2020, there were 109,836 abortions performed on residents of England and Wales. This compares with 105,540 over the same period in 2019. For every month between January to April of 2020, there were more abortions performed compared with the corresponding month of 2019. In April 2020 there were just over 4,500 more abortions compared with April 2019. In May and June 2020, the number of abortions performed was less than the corresponding month in 2019.'[14]

Additionally, the demand for illegally sourced abortion pills has ceased after the passing of the telemedicine regulations. Women on Web, who provide online abortion pills to women in Great Britain outside of the Abortion Act 1967, reported a drop in users from an average of two per day to none.[15] Women are now able to access safe, legal, and effective care within the existing care system, so do not need to turn to illegal means. The evidence strongly suggests that telemedicine has increased accessibility of care in abortion services and therefore this should be continued after the period of the pandemic.

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?
Yes, it has had a positive impact

Telemedicine has allowed women to access abortion services more discreetly, strengthening their right to privacy and confidentially. It has been implemented with strict safeguards to ensure that women can speak to the medical professional privately and there are procedures in place to safeguard against coercion. Conversely, not requiring women and girls to attend a clinic, possibly on multiple occasions, has enabled women to access these services without having to disclose to their employers or household members the reason for their absence. This is most significant for women in abusive relationships who would often find it difficult to access a clinic without the knowledge of their partner. Telemedicine allows these women and girls to make appointments more discreetly and at times when they feel safer to do so.

Telemedicine has significantly reduced the risk of women and girls being harassed and intimidated by anti-abortion protestors while accessing abortion services. This undermined their right to privacy and confidentiality while accessing healthcare to which they have a legal right.

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[13] Aiken, Abigail, et al. 'Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study' December 2020 [Awaiting publication] doi: https://doi.org/10.1101/2020.12.06.20244921

[14] Department of Health and Social Care, *Abortion statistics for England and Wales during the COVID-19 pandemic.* December 2020. https://www.gov.uk/government/publications/abortion-statistics-during-the-coronavirus-pandemic-january-to-june-2020/abortion-statistics-for-england-and-wales-during-the-covid-19-pandemic

[15] BPAS, 'Pills By Post: English Government's public consultation on continue home use of both pills for early medical abortion response guide' December 2020. https://www.bpas.org/media/3417/england-ema-consultation-template-response-december-20.pdf

> 'Over recent years there has been an escalation in anti-abortion activity outside clinics in the UK. Women attending pregnancy advice and abortion centres are now regularly exposed to groups of anti-abortion activists standing directly outside. Many of these activists bear large banners of dismembered foetuses, distribute leaflets containing misleading information about abortion, and follow and question women as they enter or leave the centres. Often, these people carry cameras strapped to their chests or positioned on a tripod. Women report feeling intimidated and distressed by this activity as they try to access a lawful healthcare service in confidence. Staff at clinics have on occasion needed escorting from the building by the police. Recently, NHS staff on premises where a clinic is located have felt so intimidated by the presence outside they have asked for the abortion service to be withdrawn.'[16]

We believe women and girls can more effectively exercise their right to privacy through the telemedicine system, as they are simply not exposed to such treatment.

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.
Yes, it has had a positive impact.

Telemedicine allows for a more person-centred approach to healthcare, where the wellbeing of the patient and their best interests are the prime consideration. The Abortion Act 1967 is over 50 years old and has not been updated to reflect changes in medical technology and practice, which have rendered some of its requirements no longer medically necessary. Indeed, those requirements are now unduly burdensome upon patients.

As described above, the new approach has allowed more women to access care and to do so earlier and more safely. The reduction in costs and resources required compared to the previous in-person model could be freed up to provide other women's healthcare services, such as contraception and sexual health testing.

Question 5: Have other NHS services been affected by the temporary measure?
No

Telemedicine, to the best of our knowledge, has not adversely affected any other NHS service. If anything, it has reduced the cost and resources of the NHS providing abortions.

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?
As stated in our answer to question 1, abortion is an overwhelmingly safe medical procedure. Doctors and clinicians should give the same information in telemedicine consultations as they would under the previous model. When it comes to determining medical advice, we support this responsibility being placed upon medical clinicians, rather than the Government, who are best

[16] BPAS, Back Off Campaign, https://back-off.org/the-campaign/

placed to determine this.

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?
Yes, disadvantages.

In cases of domestic violence, it is harder for women and girls to access in-person clinics safely. A return to this system could put them in danger. Continuing telemedicine would remove this risk. The temporary measure has been successful and making it permanent will not adversely affect any protected characteristics under the Equality Act 2010. Sufficient and substantial efforts are made to ensure that clinics are responsibly assessing and putting in measures to safeguard women. Remote consultation with healthcare professionals follows the same standards as face-to-face consultations and enough information and time are provided to allow for questions and informed consent. With all of these measures in place, there are no external dangers that could hinder a woman's safety, any more than an in-clinic visit.

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?
Age: Younger women and girls under 18 are disproportionately likely to lack the ability to travel for care as a result of lack of access to private transport, or the money to travel on public transport. They are also disproportionately likely to be dependent on others who they may not want to know about the procedure. Telemedical abortion services increase accessibility for this group and enable them to better preserve their privacy.

Pregnancy or on maternity leave: The change has expanded healthcare access and improved safety for women and girls during pregnancy as described above.

Disability: Women with both physical disabilities and certain mental health issues may struggle to access in-person medical care, particularly where they don't have their own means of transport or require an escort to attend a clinic. Some women may be unable to travel at all. Telemedical abortion services increase accessibility for this group and enable them to better preserve their privacy.

Race and Religion/Belief: Members of all communities in the UK access abortion services, even where they belong to a religious group that disagrees with abortion. Telemedical abortion services increase accessibility for this group and enable them to better preserve their privacy.

Sex: The legal provisions surrounding the accessibility of care are a fundamental part of women's healthcare and the exercise of women's rights in this country. Abortion should not be subject to unnecessary, politically driven restrictions which are not in place for other forms of gender-neutral healthcare. Women have the right to access abortion and should have the right to access high-quality, evidence-based care.

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?

Women with lower incomes or who live in areas where they have little access to transport are disproportionately affected by the barriers to accessing in-person services. This means that these women are more likely to delay appointments until later into their pregnancies and therefore are more likely to have complications. Telemedicine has reduced these barriers and therefore benefited women from more deprived backgrounds.

Question 10: Should the temporary measure enabling home use of both pills for EMA become a permanent measure?
Become a permanent measure

For more details, information, and evidence, contact Humanists UK:

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