

Pills by Post

BPAS response to the
government consultation on
home use of both pills for early
medical abortion up to 10
weeks gestation in England

February 2021



Background

About us

The British Pregnancy Advisory Service (BPAS) is a reproductive healthcare charity that offers pregnancy counselling, abortion care, miscarriage management, contraception and testing for sexually transmitted infections (STI) to 100,000 women each year.

We are the largest abortion provider in the UK, operating around 60 clinics across Great Britain. We are commissioned by Clinical Commissioning Groups to provide NHS-funded abortion services to women from across England. We also provide funded care under varying arrangements to women from Wales, Scotland, and Northern Ireland.

Prior to and throughout the COVID-19 pandemic, we have advocated for the ability of women to access abortion care in a way that does not endanger their health or that of their family, and to ensure that the law does not stand in the way of accessible care and clinical developments.

Covid-19

Novel coronavirus (SARS-COV-2) is a new strain of coronavirus causing Covid-19, first identified in late 2019. Since March 2020, Covid-19 has been spread domestically within the UK, resulting in a series of social restrictions to limit and control transmission including national and local 'lockdowns', restrictions on travel, and limitations on household mixing.

Clinical guidance

In March 2020, in response to the risk to abortion providers and people seeking abortion care, the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of Midwives, the Faculty of Sexual and Reproductive Healthcare, and the British Society of Abortion Care Providers produced clinical guidance for the provision of abortion care during the COVID-19 pandemic.

This guidance recommends a pathway for the provision of Early Medical Abortion with a focus on telemedicine to minimise risk and maintain provision of abortion as a time-sensitive, essential service. Specifically, it recommends:

- Providing remote consultation via video or telephone call and limiting in-clinic care.
- Limiting ultrasound provision to only where necessary – such as symptoms or history of ectopic pregnancy, the presence of an IUD or IUS, or uncertainty about the date of last menstrual period.

Changes to licensed premises

Under the Abortion Act 1967, abortion treatment may only be provided in NHS hospitals and on premises licensed for the purposes by the Secretary of State for Health and Social Care.

At the beginning of the outbreak, women with pregnancies up to 10 weeks' gestation were able to take the second part of an Early Medical Abortion (misoprostol) at home but had to attend a hospital or clinic to take the first medication (mifepristone).

On 30th March 2020 in England, and 31st March in Scotland and Wales, women's homes were licensed to allow home use of mifepristone. In England, this applies to care up to 9 weeks and 6 days' gestation.

The consultation

The initial approval for home use of mifepristone in England is time-limited to a maximum of two years (March 2022). The UK Government, alongside the Scottish and Welsh governments, have undertaken public consultations to determine whether this approval should be permanent.

The BPAS service

BPAS's telemedical EMA service, Pills by Post, was launched on 8th April 2020 to provide nurse- and midwife-led consultations over the telephone or video call, with medication posted to a woman's home address where she was suitable for treatment.

BPAS's Pills by Post service consists of:

- A consultation with a nurse or midwife which includes a pregnancy options discussion (continuing the pregnancy, pursuing adoption, or having an abortion), assessment of safety at home, medical history, assessment of gestational age by last menstrual period, determination of the need for an ultrasound, and a discussion about STI testing and ongoing contraception.
- Additional safeguarding for under-18s including a video call with BPAS nurses and midwives, questions designed to assess the likelihood of Child Sexual Exploitation, and discussion of the requirement to have a named, responsible adult over the age of 18 present in the house while they undergo the termination. Where an under-18 has a social worker or contact with mental health services, their caseworker will be informed. If this video call cannot be performed safely or where concerns are raised, clients are brought into the clinic for a face-to-face discussion.
- If required, an in-person appointment for ultrasound scan (including, at earlier gestations, transvaginal ultrasound), safeguarding, or pre-treatment blood tests.
- The review of notes and assessment by two separate doctors who will either ask for further information or provide the legally required signatures and prescribe the medication.
- Postage of mifepristone and misoprostol, codeine for pain management (if suitable), a low-sensitivity pregnancy test to take three weeks after treatment to confirm success, and, where requested, a supply of the progestogen-only contraceptive pill. Clients can track the parcel, it is 'signed for', and delivered in plain packaging. Clients may also collect this package from a BPAS clinic if they prefer.
- Online and video instructions, and access to BPAS's 24-hour aftercare line staffed by BPAS nurses and midwives who answer medical queries and provide help and assistance to clients. Under-18s and vulnerable adults will receive a telephone call three weeks after treatment to ensure that the abortion was completed successfully, and no further care is required.
- If a client under 18 or a vulnerable adult does not attend a scheduled appointment or cannot be reached for follow-up, BPAS will contact their registered GP.

The BPAS position

BPAS has provided more than 40,000 telemedical abortions since the home use of mifepristone approvals in March 2020. The change in regulation to enable the provision of telemedical abortion services to clients in the early stages of their pregnancy has been essential during lockdown and is necessary to provide the best possible care going forward.

Based on our experience of this service, clinical evidence, and our history of providing high quality care to women, we believe that telemedical abortion is safe, effective, and makes abortion services more accessible.

We support the permanent approval of mifepristone for home use across the UK.

Consultation response

Throughout this response, we will refer to figures related to BPAS's own service both before and after the introduction of our Pills by Post pathway, in addition to recent studies of the impacts of the introduction of telemedical abortion care in the UK:

- 'Aiken study' - Aiken, A., Lohr, P.A., Lord, J., Ghosh, N. and Starling, J. (2021), Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study. BJOG: Int J Obstet Gy. Accepted Author Manuscript. <https://doi.org/10.1111/1471-0528.16668>
- 'BPAS acceptability study' - Marielle Meurice, Katherine Whitehouse, Rebecca Blaylock, et al. 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. Authorea. December 02, 2020. DOI: 10.22541/au.160691768.87050587/v1. <https://authorea.com/doi/full/10.22541/au.160691768.87050587>
- 'Lothian study' - Reynolds-Wright JJ, Johnstone A, McCabe K, et al. Telemedicine medical abortion at home under 12 weeks' gestation: a prospective observational cohort study during the COVID-19 pandemic. BMJ Sexual & Reproductive Health Published Online First: 04 February 2021. doi: 10.1136/bmj-srh-2020-200976. <https://srh.bmj.com/content/early/2021/02/04/bmj-srh-2020-200976>

Safety

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?

BPAS believes that the temporary approval has had a significant positive impact on the provision of abortion services. Abortion remains safe, effective, and more accessible and convenient than ever before.

Clinical risk

Abortion is a low-risk procedure which in all instances is safer than continuing a pregnancy to term. Clinical risk is an aspect of all forms of medical care – which is managed by the patient's clinical team in discussion with the patient. In line with the position of leading medical bodies such as the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives, we believe that abortion is best managed as medical care between a woman and her clinical team.

Since the original approval, abortion providers across Great Britain have worked hard to establish a safe, effective, and accessible telemedical abortion model at a time when all other healthcare has been under substantial pressure.

Abortion and risk

Before this latest change facilitating telemedical abortion, more than 100,000 women a year self-managed their abortion at home – but were required by the law to attend a clinic to take one pill. The law has also never required women to have a scan, and clinical guidelines make clear that routine scanning for every woman is unnecessary.

It should be considered a positive aspect of this change at a clinical level that it is supported by a large number of medical Royal Colleges and clinical groups, including:

- Royal College of Obstetricians and Gynaecologists
- Royal College of Midwives
- Royal College of Nursing
- Royal College of General Practitioners

-  Royal Pharmaceutical Society
-  College of Radiographers
-  Faculty of Sexual and Reproductive Healthcare
-  British Society of Abortion Care Providers
-  British Medical Association

Telemedicine outcomes

A large cohort study based on Independent Service Provider data from England and Wales recently published by the British Journal of Obstetricians and Gynaecology (Aiken, A. Lohr, P. Lord, J. Ghosh, N. Starling, J. Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study <https://doi.org/10.1111/1471-0528.16668>) has found that when evaluating 52,142 medical abortions – 22,158 prior to the change in regulation and 29,984 in the telemedicine-hybrid cohort (in which women only received in-clinic treatment/scanning when indicated and the majority received telemedical care) telemedical abortion provision is effective, safe, acceptable, and improves access to care.

The study found that there were no differences in success rates between the two groups (98.2% vs 98.8%) and no differences in the prevalence of serious adverse events (0.04% vs 0.02%).

In the telemedicine-hybrid group, the effectiveness for abortions conducted using telemedicine was 99.2% compared with 98.1% in the traditional group.

Ectopic pregnancies

The overall rate of ectopic pregnancy and complications related to ectopic pregnancy are low in the UK. According to NICE, the rate of ectopic pregnancy is 11 per 1,000 pregnancies, with a maternal mortality of 0.2 per 1,000 estimated ectopic pregnancies. In line with other research, the Aiken study (<https://doi.org/10.1111/1471-0528.16668>) found that the incidence of ectopic pregnancy was significantly lower in the abortion population – with 2 in 1,000 clients presenting with an extrauterine pregnancy.

Women seeking abortions are screened for ectopic pregnancy and have historically been exposed to ultrasound scanning at an earlier stage than those who intend on continuing their pregnancies, even though the risk of ectopic pregnancy is higher in the latter group. In maternity care, ultrasound is not used for routine screening of asymptomatic women, and the first routine ultrasound scan does not take place until 12 weeks.

An important part of telemedical consultation and scan screening for abortion services is assessing a woman for likelihood of ectopic pregnancy – including the taking of obstetric history, questions about abdominal pain or bleeding during this pregnancy, and risk factors for ectopic pregnancy. Any woman who is symptomatic of an ectopic pregnancy or who has a risk factor for an ectopic pregnancy will be assessed with an ultrasound scan and referred to an Early Pregnancy Assessment Unit if required.

NICE guidelines are clear that Early Medical Abortion can be provided before there is definitive evidence of an intrauterine pregnancy, and the nature of scanning at very early gestations means that detection of extrauterine pregnancies may be both difficult and result in high rates of false positives. There is no clinical risk to patients with an ectopic pregnancy of taking abortion medication – the ultimate outcome is that there is no bleeding and that patients are then referred into Early Pregnancy Assessment Units.

The Aiken study (<https://doi.org/10.1111/1471-0528.16668>) found that the telemedical model 'resulted in very low rates of undiagnosed ectopic pregnancy' (0.03%), with a 'not significantly

different' number of ectopic pregnancies detected after treatment in the new pathway compared to the previous pathway.

Ectopic pregnancies diagnosed after abortion treatment present a minimal risk which is present regardless of the care pathway. Overall, the incidence of ectopic pregnancy is very low in abortion patients and is not influenced by the care pathway, assessment for ectopic takes place at an earlier gestation in abortion care than for women continuing pregnancies, the majority of ectopic pregnancies are detected prior to treatment in both the in-person and telemedical care pathways, and ectopic pregnancies are not complicated by Early Medical Abortion treatment.

Late for LMP presentations

Since the change in clinical practice to rely on Last Menstrual Period (LMP) rather than a scan for determining gestational age, there have been a very small number of cases involving gestations outside the 10-week limit for pills at home. The initial indication was that this risk would be around 1 in 1000 – Or 0.1%. According to the Aiken study, this risk is – in fact – significantly lower at 0.04%. These abortions were all completed at home without additional medical complications.

In relation to broader antenatal care, this is 25 times lower than the percentage of pregnancies which end in miscarriage in the second trimester (12-24 weeks). The current level of risk means you would need to compel 10,000 women to undergo a transvaginal or abdominal scan – which women often find invasive and unpleasant – in order to prevent four cases of a woman being treated whose pregnancy was in excess of 10 weeks.

Decisions about scanning are not within the purview of this consultation or subject to Government approval, but based on clinical guidelines and best practice. There could be no clinical justification for supporting an invasive intervention on this basis and for this reason, routine scanning will not be resumed. This means that whatever decision is reached about the future of home use of the first part of Early Medical Abortion, the extremely low risk of a woman receiving treatment outside of the 10-week gestational window will remain.

Covid-19

In addition to the clinical aspects of abortion care, the change in regulation has meant that women who have no clinical need to attend the service in person have been able to avoid the risks of contracting or transmitting Covid-19. Across the UK, roughly 200 women a day have been able to avoid attending a clinic – enabling services to practice improved infection control and minimising the risk to those women who are clinically vulnerable.

Although this protection from infection may be Covid-specific for many women, there are many women who may need access to abortion going forward who are Clinically Extremely Vulnerable, and for whom attending healthcare facilities may carry with it risks to their health even without the risk of Covid – including women with autoimmune disorders, who are undergoing treatment for cancer, who are transplant patients, or who have severe respiratory conditions. It should also be noted that at the current time there is no certainty about the future prospects for living alongside Covid-19, and that the Covid-specific risks to patients may exist well beyond March 2022.

Accessibility

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?

We believe there has been a positive impact on accessibility as a result of telemedicine.

Accessibility and convenience

We know that for many women, being required to take medication in a clinic is difficult. Clinics

can be far from a client's home, they need to take time off work, associated travel and childcare costs can be high, appointments can be lengthy because of the legal requirement for two doctors to authorise the abortion, and because of the requirement to take mifepristone in-clinic and the second set of pills 24-48 hours later, a woman cannot choose when she passes her pregnancy.

These difficulties are particularly acute for women in more rural and remote parts of England such as Berwick upon Tweed and Northumberland, where travelling to an abortion clinic at any gestation requires a 1 hour journey each way (or 1hr40 on public transport).

Telemedicine helps us treat women in a way that fits in with their lives – while ensuring they are treated by trained professionals, within the regulated care system, and provided with the support they need.

BPAS continually evaluates our services to ensure they meet women's needs. Following the roll-out of our Pills by Post service, we conducted a review with 1333 clients. The full paper has been submitted to the international journal Contraception and is available here -

<https://authorea.com/doi/full/10.22541/au.160691768.87050587>. Key findings included:

- 97% of clients were satisfied or very satisfied with their experience with BPAS
- 95% were satisfied or very satisfied with having a telephone consultation
- 80% would opt for Pills by Post or telephone consultation and pill collection from a clinic if they needed an abortion in future.

Waiting times

Since telemedicine was introduced, across the BPAS service, waiting times have fallen by more than a week. Particularly for women in areas with a clinic open a day or two a week, this simply would not be possible without telemedicine. Shorter waiting times mean that abortions can be accessed at earlier gestations, minimising the risk of complications.

The Aiken study (<https://doi.org/10.1111/1471-0528.16668>) found that mean waiting times were 4.2 days shorter in the telemedicine-hybrid cohort than prior to the change in regulation – and that 40% of treatments were provided at ≤6 weeks' gestation compared to 25% in the traditional cohort. This increase is significant at both an individual and population level. The earlier an abortion can be performed when a woman knows she does not wish to continue the pregnancy, the greater the protection of women's health.

We are also aware that NHS-led services have experienced large declines in waiting times. Mystery shopping performed by BPAS in 2019 for the (then) Welsh Assembly Cross-Party Group on Women's Health found that many abortion services operated only a day or two a week, and that waiting times from contact to treatment averaged around 17 days. Since the change in regulation allowing telemedicine, waiting times in these services have declined to under 5 days – within NICE and medical guideline targets.

Privacy and confidentiality

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?

We believe that telemedicine has had a positive impact on privacy and confidentiality of access.

The requirement to travel to an abortion clinic carries with it unavoidable issues which can compromise privacy and confidentiality, namely time off work, childcare, and anti-abortion protesters.

Time off work

Where a client has to take mifepristone on clinic premises, the time off work is not only required to be for the appointment (which historically, given the requirements of the Abortion Act regarding two doctors' signatures, may last several hours), but also 24-48 hours later once she has to administer misoprostol to complete the abortion. Attempting to take the misoprostol earlier or later can have a detrimental impact on side-effects or efficacy. If the only in-clinic appointment available is on a Monday, for instance, the woman will need to take her misoprostol on Tuesday or Wednesday, regardless of her working patterns. This can require disclosure of her pregnancy to her employer, or in some instances an erroneous request from employers for a sick note. Telemedicine enables the client to take the medication at a time and day that works for her so she can minimise the impact on her employment or education.

Childcare

In 2019, 55% of women who had abortions were already mothers. Given the nature of the service and the emotional toll on women attending, abortion services generally do not allow children to attend with their mother/parents, so if children are not in school, childcare will be necessary. For women who cannot afford professional childcare, this may mean having to disclose to family members or friends why they need care at a particular time or for a lengthy duration. For others, particularly those with children with complex needs, childcare may be next to impossible to find – and may pose a serious access problem.

As a result of this and potentially wide time or commitment pressures, the provision of telemedical abortion care has a disproportionately positive impact on women who are already mothers - during the first quarter of Pills by Post within BPAS, 63% of women who opted for Pills by Post were mothers already, compared to 52% of women who had an Early Medical Abortion via another pathway.

This issue also has a varying effect on women with different ethnicities. In BPAS clients from 2020, 64% of women who listed their ethnicity as 'Black or Black British – Caribbean' were already mothers, compared to only 40% who identified as 'Mixed – White and Asian'. This variation is not limited to the pandemic, with 2019 proportions varying from 38% (Chinese) to 60% (Asian or Asian British – Pakistani).

Anti-abortion clinic protesters

In 2019, more than 100,000 women in England and Wales had to attend an abortion clinic that had been targeted by anti-abortion protesters in the past year. These protesters gather outside the gate of or entrance to clinics for several hours at a time, and seek to approach women to talk to them in an effort to dissuade or deter them from accessing abortion care. Some of these protesters wear body cameras or film clinics. This is a concern that has been raised repeatedly with the Home Office, and which BPAS works with councils and police to attempt to reduce the impact of activity.

The nature of this activity is that individuals are close enough to women to identify them, and as their ultimate aim is to stop women having abortions, it is a reasonable concern that if a local person recognises a particular client, their information might be shared. In recent years, we have received reports of an anti-abortion group live-streaming their protests outside a clinic on Facebook, a woman who had to attend a clinic twice and both times encountered a protester who she knew from her children's school, and a woman who reported that a protester she encountered had reported her attendance back to her (disapproving) family.

With the current legal arrangements, there is no way to deal with the protesters that target 44 clinics in England. The only way for women to protect their privacy is to not have to attend a clinic.

Provision of abortion services

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.

The change has had a positive impact.

Care provision

Abortion providers have variously described the changes in regulation as ‘revolutionary’ and ‘one of the success stories of the pandemic’ – not because of the nature of the change, but the ability to apply evidence-based best practice to abortion care in the UK in a way the law previously didn’t allow. The change has enabled services across Great Britain to provide safe and effective services that are more accessible than ever before.

NHS services have reported that telemedicine has enabled them to provide services when staff have been redeployed to deal with Covid-19 – indicating that high quality abortion services can now be provided with fewer staff.

Prior to the change, clients were required to attend services for prolonged periods – for face to face consultations, scanning, two doctors’ signatures, and administration of mifepristone. Although the change in regulation concerns only the administration of mifepristone, the change has enabled providers to reconsider how services are provided and the needs of clients.

Cost-effectiveness

An upcoming study – Hawkins et al 2021: EMA by TM abortion in UK - a cost effectiveness analysis – has found that the change to telemedicine has the potential to save the NHS more than £3 million a year through the reduction in gestational age, shift towards Early Medical Abortion, and the low complication rates reported in Aiken. In NHS services, these savings are particularly notable – accounting for 2/3rds of the savings despite providing only 25% of abortions – as a result of the reduced need for theatre space, day beds, and under pressure speciality professionals such as anaesthetists. These savings will enable CCGs and abortion providers to focus on using their limited funding to improve service provision e.g. for later or more complex care, contraception, or STI testing.

Service innovation

No matter the change in regulation around the location where a woman can administer the first pill in an Early Medical Abortion, BPAS had already started to move towards scanning only as indicated as a service improvement prior to the COVID-19 pandemic. BPAS will not be reverting to routine scanning, which is not clinically indicated, can be invasive (particularly if transvaginal, as is often the case in early pregnancy), and physically and emotionally challenging for clients. Based on our conversations with other providers, this is also their intention.

This change has led to the provision of higher quality clinical care, and no matter where women are allowed to take abortion medication, clinical services will not be going back to their previous methods of provision.

Wider NHS services

Have other NHS services been affected by the temporary measure?

BPAS has a 24-hour aftercare helpline which is provided to all clients we treat. With the greater proportion of Early Medical Abortions taking place during the pandemic, our aftercare line supports women at every stage – with the principle reasons for contacting including questions about administration, asking about normal levels of pain and/or bleeding, or to discuss aspects of care such as the follow-up pregnancy test. The BPAS acceptability study

(<https://authorea.com/doi/full/10.22541/au.160691768.87050587>) found that 85% of women treated through telemedical abortion services did not make contact with a Healthcare Professional during or after their abortion. Of those that did, 78% contacted the BPAS aftercare service. Rates for contact with outside professionals were consistent with the figures for early medical abortion care without a telemedical component.

Before the approval of mifepristone at home, about 150,000 women every year were passing their pregnancies at home across Great Britain. Even prior to the approval for the home use of misoprostol, women were not remaining in clinic to pass their pregnancy, but instead travelling home often while suffering the early stages of miscarriage. Complications in need of healthcare support are disproportionately likely to happen at this stage rather than at the point at which mifepristone is administered – indicating that pressure on wider healthcare services will not change in a meaningful way.

The large cohort study (<https://doi.org/10.1111/1471-0528.16668>) found that there were no differences to complications after the change to telemedical abortion care, and indeed that some of complications which may require further abortion service involvement such as continuing pregnancies had declined. As a result, there is absolutely no reason to suggest that there has been a wider impact on NHS Wales services as a result of the change.

More broadly, telemedicine has been accompanied by self-referral into abortion services in a number of areas where this was not already in place, e.g. in Worcestershire and Herefordshire. This means that there is less pressure on sexual health, contraceptive, and GP services which may previously have been required to refer patients into the abortion service – or to provide signatures for the HSA1 prior to treatment taking place. At least one area in Great Britain has been able to stop requiring either referral from a local GP or having to delay care for clients as a result of being able to provide HSA1 signatures between a telephone consultation and the dispatch of abortion medication – reducing the pressure on wider healthcare services.

Information for abortion clients

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?

The risks and relevant information for consent regarding later than expected delivery after telemedical care is a fundamental part of BPAS's provision. Clinicians must share all material risks with their patients, as well as any it would be reasonable to think the individual patient would attach significance, as established by the Supreme Court case *Montgomery v Lanarkshire Health Board* [2015] UKSC 11. It would be both problematic and unnecessary for Government to mandate the provision of any particular information in relation to abortion, as the communication of material risks is already covered by existing case law.

Our COVID-19 Pandemic Clinical Pathways and Standard for Clients Seeking Abortion Care operational policy provides guidance for trained nurses and midwives on how to estimate gestational age. The discussions with clients should involve determining the first day of their Last Menstrual Period (LMP), determining that their cycles are regular, and ensuring that their cycles have been regular for at least 1 year (or 3 months post-pregnancy). Nurses and midwives further seek to ascertain whether their reported last period was 'normal' – was it when expected, was it shorter or longer than usual, was it more or less heavy than usual. This enables clinicians to distinguish between LMP and other pregnancy-related bleeding. This guideline enables clinicians to determine gestational age accurately with a high degree of certainty.

The BPAS guideline also requires clinicians to ensure that clients – as part of the informed consent discussion – understand that errors in LMP may mean that the pregnancy is greater in

gestation than estimated. The risk in the guideline is currently listed as '1 in 1000 but may be lower', recognising that the Aiken study found that there is a 1 in 2500 risk. The clinician discusses with the client that this means that (1) the medications may not work, or (2) that the medications may work but cramping and bleeding may be greater than expected and the foetus may be much more developed than expected.

This discussion is an integral part of the consultation and consent process, and is the first item on the 16-item consent form to be filled in by the clinician providing the consultation.

Safeguarding

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?

There are disadvantages to safeguarding by requiring clinic attendance.

In fact, based on evidence from the past year, forcing clinic attendance is likely to result in reduced safeguarding disclosures and increasing numbers of vulnerable women and girls turning to illegal, unregulated sources of abortion medication online.

The existing system of telemedicine, with in-person care where necessary, provides the best options for women who are victim-survivors of sexual violence or domestic abuse, particularly those for whom leaving home for the length of time needed to attend appointment would be unsafe.

Abortion providers ask every client we treat whether they feel safe at home – both those treated in-person and via telemedicine. BPAS provides referrals to social services and the police, and we work with local charities and organisations to help women who need us. Since telemedicine started, we have found that clients are more comfortable disclosing domestic abuse and other issues to us because of their more familiar setting – enabling us to better support them, whatever their need.

In the first quarter of the BPAS Pills by Post, just under 10% of our clients underwent an enhanced safeguarding risk assessment – a 12% increase compared to March 2020.

These are undertaken as a result of a woman's personal circumstances, information disclosed to BPAS staff, the involvement of social services, concerns about human trafficking or modern slavery, legal requirements such as risk or presence of FGM, or the fact that they were under 18 years of age when presenting. This proportion suggests teleconsultations are not a barrier to identifying safeguarding concerns, and indeed some women may find it easier to disclose when in the privacy and familiarity of their own surroundings as opposed to a clinical environment.

BPAS has also evaluated our Pills by Post service specifically in relation to safeguarding and domestic abuse, with the following outcomes:

- 99% of clients said that they were able to 'find a private space, with no interruptions, for the duration of the telephone consultation'
- 93% of clients said they would have felt able to share any concerns they had about their safety at home and/or in their relationship
- 24% of clients said that they discussed concerns about their safety at home with a member of BPAS staff.

These findings reflect the conclusion that telemedicine is not a barrier to the discussion of safeguarding or domestic abuse concerns. Where BPAS is treating an adult, there will be a discussion about whether she wants to involve the police or be referred into services such as a

refuge. Many women will not want to pursue further support at that moment, although may engage once the termination is complete, and as with all other healthcare providers, we do not require women to engage with other services in order to provide care. However, where we believe there is a risk either to existing children or, if the woman opts to continue her pregnancy after her consultation, to her child when it is born, we are under a legal obligation to involve social services. This is also the case where we are concerned about girls and young women under the age of 18 who present to us.

We also know that since we launched this service, women who have previously struggled to access in-clinic care, including women in abusive relationships, are no longer sourcing help outside the regulated healthcare system. Services such as Women on Web which have previously been contacted by women who were unable to access care as a result of their home circumstances and thus needed to receive (illegal) abortion care at home report that this care is no longer necessary and that women are instead seeking care via legal means.

Equalities impact

To what extent do you consider making permanent home use of both pills could have a differential impact on groups of people or communities?

Everyone should be able to access safe, free abortion but with a legal requirement to attend a clinic, that doesn't happen. Disabled women, LGBT people and care-experienced women and girls in Wales may experience difficulties in accessing reproductive health services, and the costs of travel and childcare are barriers to abortion which have a greater impact on women facing multiple deprivations and discrimination.

Telemedicine enables providers to tailor care to individual women and their needs. Some women are disproportionately likely to encounter difficulties in accessing in-person care – including mothers, victim-survivors of sexual violence, women experiencing domestic abuse, teenage women and girls, women from deprived areas, LGBTI people, disabled women, BAME and migrant women, homeless women, women with mental health or substance use issues, and women with insecure immigration status.

Particularly:

- **Race/ethnicity and religion** – BPAS cares for women of all ethnicities, and 22% of our clients identify as an ethnicity other than 'white' – higher than the level in the population as a whole. Women from certain religious or cultural backgrounds may experience greater difficulties in accessing in-person care as a result of their living or social arrangements. Travelling a greater distance to a standalone hospital or clinic may be impractical or impossible if they are unable to attend healthcare appointments alone. Further, we have received reports from religious women that their experience of anti-abortion protesters outside clinics has a negative impact on their mental health and in some instance and caused severe anxiety.
- **Age** – younger women and girls may find it more difficult to travel to in-person appointments to lack of access to private transport, the cost of public transport, and education or work commitments.
- **Disability** – Disabled women may have different access needs which affect their capacity to visit hospitals and clinics in person, or mean that they *must* forgo privacy in order to have support to attend or access premises. This applies to women with physical disabilities who may also struggle to access scans, but also women with disabilities such as agoraphobia which limit their ability to attend healthcare premises. Under the previous regulations, there was no way to make adjustments to care for disabled women outside a clinic setting, meaning they may struggle to access safe,

legal abortion care.

- **Pregnancy and maternity** – Women who are already mothers account for more than half of all abortions across the UK and 63% of women receiving Pills by Post from BPAS. Requiring all women to attend clinics for lengthy appointments often means that childcare has to be found, and either privacy compromised, or money found to pay for professionals. This concern is particularly acute where women are caring for a child with special needs where respite care is unavailable.

Deprivation and geography

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?

Based on BPAS data from the first quarter of providing Pills by Post (April – June 2020), compared to the same quarter in 2019 (April – June 2019), telemedical abortion and our Pills by Post service has a disproportionately positive impact on abortion care for women from more deprived backgrounds and for women from more rural and remote areas who had previously experienced longer waiting times and higher gestation at treatment.

Deprivation and socio-economic disadvantage

As shown in the 2019 Abortion Statistics, the more economically disadvantaged a woman is, the more likely she is to need to access abortion. Information from within the BPAS service shows that this has differential has worsened during the pandemic – with our poorest clients (Decile 1 of IMD) now being more than twice as likely to attend BPAS for care than the richest (Decile 10) when adjusted for population distribution, compared to only 60% more likely in 2019. In the first quarter of Pills by Post, 16.5% of our clients were from Decile 1, compared to 13.7% in 2019 (and 10.9% in the population as a whole).

BPAS knows that more deprived women are disproportionately likely to ask us to delay care that requires them to travel until they are next paid or receive their benefits – because existing NHS travel costs schemes do not fund self-referred abortion travel.

Women face structural issues of socio-economic disadvantage which may leave them struggling to access care which provided from specialised clinics or hospitals, including:

- The high cost of childcare
- Families where women do not have access to an independent income and wish to keep their travel and treatment private
- The disproportionate likelihood of being employed in precarious jobs or with zero-hours contracts, which may make it more difficult to get time off work for appointments and to pass the pregnancy in the days subsequent to the appointment
- Disproportionate reliance on public transport which affects the cost, time, and difficulty of attending an in-person appointment – particularly in more rural and remote areas

These difficulties are borne out in the impact of our Pills by Post service – showing that the regulatory change has made abortion more easily accessible to the most disadvantaged women:

- Clients from more deprived areas have had a 46% greater reduction in gestation than clients from the least deprived areas (9.45 days reduction compared to 6.48 days)
- In 2020, there was a much lower variance in gestation based on deprivation compared to 2019 – 0.69 vs 2.69 – meaning that the difference between gestational age at

procedure between the richest and poorest clients has declined by nearly 75%

- For Early Medical Abortion only, clients from more deprived areas have had a 30% greater reduction in gestation than women from the least deprived areas (5.85 vs 4.51)
- Clients from the most deprived areas have had a 22% greater decline in waiting times than clients in the least deprived areas
- There is no difference in the use of Pills by Post as a proportion of all procedures by deprivation

Rural/Urban

Women from more rural areas have historically struggled to access abortion care in an equitable way – as a result of the need to travel a greater distance, issues for disadvantaged of women of accessing private transport, and the increased difficulties of spending longer away from home. As expected, the introduction of telemedicine has had a disproportionately positive impact on women from more rural areas who were particularly disadvantaged by the requirement to attend a clinic. This is despite women from the most rural ('rural sparse') areas being disproportionately likely to access abortion care – with presentations to BPAS care being 50% higher than the proportion of women of reproductive age who live in these areas.

Figures from within the BPAS service show:

- Waiting times have fallen 30% more for women living in 'rural sparse' areas than in 'urban' areas
- Gestation at treatment has fallen 12% more for women in 'rural sparse' areas than in 'urban' areas
- Women in 'rural sparse' areas were 5 percentage points more likely to access Pills by Post than women in urban areas, despite no difference in overall Early Medical Abortion preference

Consultation outcome

Should the temporary measure enabling home use of both pills for EMA be made permanent?

The temporary measure should be made permanent.

Further information

Have you any other comments you wish to make about whether to make home use of both pills for EMA a permanent measure?

The English approval for mifepristone at home differs from the Scottish approval in two key ways:

- The gestational limit is included in law; and
- There is a link to provision from a hospital or licensed premises.

Both of these can place additional pressures on providers and women in receiving the best possible care.

The ability to provide the best possible abortion care in England should be governed by clinical frameworks and guidelines, and not by the criminal law. In Scotland, the Scottish Abortion Care Providers network determined that 12 weeks' gestation was the more appropriate limit for home use of mifepristone and misoprostol – a finding supported by international evidence. Their framing also better allows effective cross-border care, and care grounded in the qualifications of clinicians providing care (doctors, nurses, and midwives in the case of England) rather than it being tied to other licensed premises.

The ability to provide mifepristone at home would also help women in England having later abortions, including on the grounds of severe or fatal foetal abnormality, who would no longer need to attend multiple, unnecessary appointments. Instead, they could take mifepristone at home before attending to pass the pregnancy in hospital.

We would recommend that the England approval of mifepristone at home is made permanent, but that it is reframed to reflect the Scottish approval – without a gestational limit in law, and focused on the qualifications of the doctors, nurses, and midwives providing abortion care.

We have made the same recommendation to the Welsh consultation.

