Women and Equalities Committee Coronavirus (COVID-19) Inquiry

Marie Stopes UK Written Response

Executive Summary

1. This submission is made on behalf of Marie Stopes UK. Marie Stopes UK is an independent provider of abortion care services throughout England, and a country programme within the global charity, Marie Stopes International. Marie Stopes UK provides quality abortion services to more than 62,000 women every year, with 42 abortion clinic locations in England. We can offer both medical and surgical abortion services, as well as counselling, and post-abortion contraception. We also provide vasectomy services to around 5,000 men every year at 25 sites across England.

2. Abortion is the most common medical or surgical procedure performed in the UK, and one in three women in Britain will have an abortion by the time they are 45.[i] Our clinics across the country support and care for those who choose to access their legal right to an abortion as outlined in the 1967 Abortion Act. Abortion is an essential service for hundreds of thousands of women in the UK every year, and an incredibly time sensitive procedure.

3. The Equality and Human Rights Commission and other organisations have expressed concerns that the COVID-19 crisis, and responses to the crisis, may have a particular impact on some people who have protected characteristics under the Equality Act 2010. The nature of our abortion care services means that our client cohort engage the protected characteristics of sex and pregnancy, as they are accessing a healthcare service specific to female reproduction, and specifically for termination of pregnancy. This means any impact on our abortion care services during the COVID-19 crisis will impact persons with these protected characteristics.

4. There are several identified issues with the provision and access of abortion care which emerged from social-isolation and other measures to prevent and manage COVID-19 infection. This submission will address six points of the Committee's Terms of Reference, while looking at the impact on individual abortion care clients and the impact on service delivery:

    - *Are there any unforeseen consequences?*
    - *If there are problems, what could be done differently/ better?*
    - *How have people have been affected by the illness or the response to it?*
    - *Have there been specific impacts on people due to them having a protected characteristic?*
    - *Are there any unforeseen consequences to measures brought in to ease the burden on frontline staff?*
    - *What needs to change or improve, which could be acted on in three weeks' time?*

5. We have seen that there have been unforeseen consequences to abortion care from both protective social distancing measures and from measures to redeploy front-line NHS staff.

6. One solution to the problem of decreased access to abortion services has been the introduction of telemedicine and the at-home early medical abortion service, but this only supports those under 10 weeks gestation and significantly is not available to those in Northern Ireland. Those seeking care past 10 weeks gestation are often our most vulnerable clients, who are now experiencing unnecessary and often considerable barriers to accessing care.

7. Further support for clients in need of either medical or surgical abortion without delay must come from the CCGs, and from Departments of Health in all regions of the UK. Women's reproductive health and rights must be safeguarded at all costs.

8. Marie Stopes UK repeats its call (alongside that of three Royal Colleges and many other organisations) for abortion care to be regulated like any other medical procedure, without arbitrary restrictions imposed through legislation enacted decades ago.[ii] The current law prevents providers from delivering best practice and has impeded our ability to respond swiftly to the COVID-19 pandemic.

Summary of recommendations

What needs to change or improve, which could be acted on in three weeks' time:

9. Ensure that Clinical Commissioning Groups across the UK allow any registered, qualified abortion provider to care for patients during this time of COVID-19 crisis response in line with the NHS constitution where a choice of provider is guaranteed when waiting times are being breached.

10. Amend the home use of mifepristone and misoprostol approval order to be in line with that of Scotland so that the arbitrary gestation limit for access to medical abortion is removed. The decision for what treatment is most appropriate should be one based on an informed choice of the client following the evidence-based advice of her clinical team, not one forced through legislation.

11. Authorise nurses and midwives to prescribe abortion medications and to certify the legal grounds for an abortion to strengthen the essential abortion care health systems against doctor absence and to avoid delays to care.

12. Remove the need for two doctors to certify the grounds for an abortion, permitting one registered medical professional (doctor, nurse or midwife) to certify the legal grounds for a requested abortion in good faith, to strengthen the essential abortion care health systems against doctor absence and to avoid delays to care.

13. Urgently provide additional emergency refuge spaces during this pandemic to accommodate the increase in domestic violence concerns identified at abortion care services, to allow for survivors of domestic abuse to safely attend abortion appointments without fear of intimate partner violence, and as a safe place for those we identify as being coerced.

14. Urgently authorise mifepristone for at-home use in Northern Ireland, to allow for a full at-home early medical abortion service via telemedicine, in line with best-practice and provision in Scotland, Wales and England.

15. Ensure that surgical abortion services are available in Northern Ireland for those post-10 weeks gestation in order to prevent the need for women to travel by plane or ferry to attend appointments in England.

Impact on service delivery

Closures and delays

16. Marie Stopes UK runs clinics out of 42 sites across England. We describe these sites as Centres (premises that only provide Marie Stopes UK services) which offer both early medical abortion and surgical abortion services, and Early Medical Units (clinics hosted from within a GP surgery or Healthcare Centre) which offer early medical abortion. We have 7 Centres and 35 Early Medical Units.

17. Many GP surgeries across the country are closed and offer telephone appointments only. This has impacted two of our Early Medical Units already, with our Southend-on-Sea Clinic and Plymouth Clinic premises closing. The closures of these host premises are out of our control. Our 7 Centres will remain open, however some of these Centres serve a wide geographical area. For example, our Maidstone Centre is the only independent abortion clinic in the county of Kent.

18. Delays to care were experienced by women who felt unsure if leaving their homes to attend their abortion appointment would class as "essential" under the government's guidelines. In the week before the authorisation of the home use of mifepristone we saw the rate of clients who did not attend their booked appointments double to approximately 15%. Now that women have access to our "at-home" service, the rate of clients that do not attend their appointment (now over the phone) has decreased lower than pre-COVID-19 rates.

19. On 30th March 2020, the Department of Health and Social Care authorised the home use of mifepristone in England which allowed clients to take both medical abortion medicines at home. The new regulations included the authorisation for doctors to certify the legal grounds for an abortion from their homes when social distancing or self-isolating. We started our at-home early medical abortion telemedicine service on Monday 6th April 2020 and now we are offering telemedicine appointments at all Centres and some of our Early Medical Units.

20. Our wait times for appointments remain within the Royal College of Obstetricians and Gynaecologists (RCOG) and the National Institute for Health and Care Excellence (NICE) guidelines, ensuring minimal delay in the abortion process, and ideally providing the assessment within 1 week of the request and the abortion within 1 week of the assessment. [iii] During the COVID-19 crisis we have been able to run 90% of all our planned clinics. However, we are aware that some other providers' services are struggling with delays up to 5 weeks for treatment. This will be a devastating delay for many women, as the at-home early medical abortion service is only available under 10 weeks gestation and some women will not realise they are pregnant until the 4th or 5th week of pregnancy.

21. Prior to government introduced measures to prevent the spread of the virus, 72% of all abortions in England and Wales were provided in the independent sector at specialist clinics such as Marie Stopes UK. During this crisis and given the pressure on acute hospitals to focus on COVID-19, this share is rising.

22. Many NHS Trusts are showing consideration for the urgency of abortion care throughout the crisis period, but they recognise the need for support from the independent sector. Our nurses, midwives, doctors and call centre teams have been asked to take on additional patients from some NHS Trusts, which are having to suspend surgical termination of pregnancy services whilst they re-direct resources. As things stand, we have been approached by 15 NHS Trusts & Clinical Commissioning Groups (CCGs) to ask if we can support them to deliver abortion services for patients in their area.

23. We have strong concerns over CCGs who have exclusive or 'sole provider' contracts with single abortion care providers. This is a high-risk approach in areas of high population, as there is no resilience should that provider run into workforce difficulties during these unprecedented times. This may mean patients having to wait longer for treatment (meaning they may fall into a higher gestation band) or indeed may have to travel long distances to receive treatment. One patient, a 29-year-old cancer patient who needs urgent radiotherapy, was attempting to procure abortion medication from illegal sources in desperation because the providers (NHS and independent) in her area could not offer an appointment. We were able to take over her care, but there were delays due to needing authorisation from the CCG.

24. There has been indication that some Trusts are not considering the urgency of abortion care, even in the midst of this crisis. In the West Midlands, a CCG has blocked us from treating two women who approached us directly as they were unable to access care from providers in their area prior to passing the gestation threshold for at-home early medical abortion services. It is our understanding that for any non-urgent NHS treatment, choice of provider is guaranteed when waiting times are being breached, in accordance with the NHS constitution and NHS Choice Framework. Here, with an urgent, time sensitive and essential service such as abortion care for women and pregnant people, the same should be true, particularly during a time of increased strain on NHS services.

Telemedicine "at-home" services

25. Prior to the introduction of 'at-home services', we modelled the 2020 abortion procedures forecast on the latest available Office of National Statistics (ONS) data for England & Wales for 2018 (published June 2019).[iv] Over three quarters (80%) of NHS funded abortions took place at under 10 weeks gestation (160,000 procedures). Of these 160,000 procedures, based on our current modelling, 13,300 service users per month on average would be eligible for at-home early medical abortion via telemedicine. Every month, this service would therefore negate the need for around 13,300 people to leave their homes to make unnecessary journeys during a period in which we are all being advised to stay at home where possible. Thankfully the ability for us to provide an "at-home" early medical abortion service has already allowed over 2,400 women to access our care without needing to break social distancing or social isolation guidelines. We know first-hand the stress, anxiety and desperation that many women seeking abortion care are experiencing during the COVID-19 pandemic. We are delighted we have been able to implement an effective service in response to the crisis.

26. Clients who meet our telemedicine eligibility criteria will be able to have their medical abortion consultation with a Marie Stopes nurse or midwife conducted remotely over the phone. They then have the option to collect a specially designed medical abortion pack from a Centre or Early Medical Unit or have it posted to their registered address in England. The new pathway follows best practice set out in NICE and RCOG/RCM/FSRH/BSACP joint guidelines to improve access for women, and particularly for vulnerable groups.[v]

27. Clients who do not fulfil the eligibility criteria, will be booked into a face-to-face appointment for a gestation scan and early medical abortion care if eligible. Clients who have specific safeguarding concerns around home-use abortion are booked into a face-to-face appointment or for a surgical abortion. Fitting of Long Acting Reversable Contraception as post-abortion contraception is available for face-to-face clients. We are able to post other methods, such as the contraceptive pill, to telemedicine clients if this is their preference.

28. Informed consent for the at-home early medical abortion consists of a dialogue between clinician and client and is evidenced and recorded within the medical records system. Clients receive a link to detailed written information and the consent form in advance of their early medical abortion consultation, and discuss it

during the consultation. We have found that this improves the quality of the consultation as the client has had a chance to consider her treatment options prior to the consultation appointment.

29. All aspects of good practice can be achieved via remote consultations. NICE guidance recommends this approach, as there is good evidence telemedicine improves access to abortion care, is acceptable to women and is safe.[vi] Counselling, safeguarding, providing information, discussing options and taking informed consent can be done effectively by phone or video link. Of course, some clients will need or benefit from face-to-face assessment, but for most this isn't necessary.

30. A two month follow up of all telemedicine clients is planned to consult with clients on their experience and preferences. We are collecting this data for research to understand the benefits and risks to our clients of the approach, so we can evaluate the impact and make future improvements to the pathway in collaboration with other providers and with one of the world's leading research units into abortion care pathways based at the University of Texas.

Staff absences

31. Since the outbreak of coronavirus, 123 members of staff at Marie Stopes UK have needed to self-isolate (approximately 27% of staff from across all departments). Our current staffing levels are 95% across the organisation with 5% off either sick or in isolation.

32. During March, of our medical workforce (not including nurses, midwives, and Healthcare Assistants) we had 2 Surgeons, 1 Anaesthetist and 4 Early Medical Abortion Physicians in self-isolation. This is from a total Medical Workforce of 12 Surgeons, 15 Anaesthetists and 14 Early Medical Abortion Physicians. We currently have 1 Surgeon absent and 2 Early Medical Abortion Physicians in self-isolation. In total, 17% of our medical workforce have been unable to provide their usual contribution to Marie Stopes UK during the coronavirus pandemic. Our nursing and midwifery team have seen 35 COVID-19 related absences, from an existing team of 120.

33. These absences impacted on our services and caused some delays to care before the authorisation of the home use of mifepristone on 30th March 2020. Our Early Medical Abortion Physicians are now able to carry out their crucial roles while in social isolation as their home is authorised as a class of place from which to certify abortions and prescribe early medical abortion medication. This is especially important as our Early Medical Abortion Physicians are predominantly younger doctors, often with young children, and so have a higher chance of having to care for dependents at home due to school closures.

34. With the number of cases of COVID-19 increasing and with a larger percentage of cases in the London area, there is a risk that several of our doctors who also work within the NHS may be redeployed to focus on NHS care for coronavirus patients. This could further affect our ability to run surgical abortion services for those over 10 weeks gestation. Of our 12 surgeons, 4 provide surgical abortion up to 14 weeks gestation, 3 provide surgical abortion up to 19 weeks gestation, 1 to 22 weeks gestation and 4 can perform abortions up to the legal limit of 23 weeks and 6 days gestation.

35. Clients who present with a higher gestation are often particularly vulnerable. In 2018, 3,602 women needed an abortion after the 20th week of pregnancy, 66% through a surgical abortion pathway. The UK has a shortage of surgeons who have the skills to perform abortions at higher gestations. We estimate that in total there are only 18 surgeons with these skills in the UK. During COVID-19 the impact of even one or two surgeons being absent from work would be significant. With rigid legal gestation limits for abortion in the UK,

any additional wait can result in highly vulnerable and high-risk women being forced to continue their pregnancy with life-changing consequences for them.

36. In the current COVID-19 crisis, the NHS is under immense pressure and our clinicians' time is incredibly valuable. To certify abortions, our independent abortion services rely on only 26 doctors (Early Medical Physicians and Surgeons) serving our 42 clinic locations.

37. To further ensure continuity of services and minimise delay to care before 10 weeks gestation, we strongly recommend task-sharing considerations, to authorise nurses and midwives to certify abortions and prescribe the early medical abortion medication in line with NICE abortion care guidelines.[vii] With increased volumes of clients being transferred to us from NHS Trust abortion services, it is essential to remove the avoidable delays to timely care.

38. The current law on abortion requires that two doctors (not nurses, midwives nor Allied Health Professionals) provide signatures to certify that the abortion being carried out is in line with the grounds outlined in the Abortion Act 1967. This requirement is a legal requirement only and is not clinically necessary. Due to innovations in accessible care since the Abortion Act 1967, independent clinics such as Marie Stopes UK that provide abortion treatment in Britain are increasingly led by Registered Nurses and Registered Midwives. In Britain, nurses and midwives working within the NHS are authorised to manage miscarriage by performing the same procedures and providing the same medication that is involved in abortion care, and yet are not permitted to perform that same care for abortion services users. There is no clinical reason why this should be the case and we strongly support task-sharing in abortion care provision for nurses and midwives to be authorised to perform procedures they are appropriately trained to provide in line with their professional body's requirements and guidelines. Delays could be made worse during this pandemic due to not being able to utilise our nurses and midwives fully.

Impact on individual clients

Barriers to accessing abortion care

39. In March 2020, schools have been closed as the UK Government announced measures to slow the spread of COVID-19, meaning many parents are now juggling working from home with full-time childcare responsibilities. Women who are single parents would find it near impossible to arrange childcare should they need to attend a face-to-face abortion care appointment during this time, due to this and social distancing guidelines. There are also instances where there is no option to leave the home; those with family members showing symptoms must isolate for two weeks and those who have certain underlying medical conditions have been asked to stay at home for 12 weeks.

40. Our early medical abortion telemedicine service was launched on Monday 6th of April and saw a 10% increase of daily calls in this week. We believe that clients were delaying booking an appointment until it was possible to take both early medical abortion medication at home. Many clients also called to change existing appointments to the new service in order to suit their need to isolate.

41. The approval order that permits the use of mifepristone and misoprostol at home in England is restricted to pregnancies under 10 weeks gestation. There is no medical rationale for this arbitrary limit, and the effect is restricted access. The Scottish government has not imposed a gestation limit on their at-home early medical abortion authorisation and leave it to clinical judgement in line with published guidelines.[viii]

42. We are communicating to clients that our clinics are still open unless they are otherwise advised, through our contact centre (One Call), our website and social media channels. We are also reassuring clients that if they are not isolating due to symptoms in their household or due to existing medical conditions and need to visit

an abortion clinic for a face-to-face appointment, that this is classed as an essential reason for them to leave their homes.

Domestic abuse

43. Given our role on the frontline of supporting women in communities across the country, we care for many who are facing domestic abuse. Domestic abuse is one of the issues most commonly disclosed to teams in our clinics. In our supportive and non-judgemental environment, people often feel more able to reach out to us about issues of protection. In some cases we are better able to identify safeguarding issues than social care organisations. Last year we identified hundreds of cases of domestic abuse, both current and historic, and made many Social Care referrals due to domestic abuse concerns. When we identify protection issues, we work collaboratively with women and girls to support them in taking whatever next steps they are comfortable with. Our priority is their safety and security.

44. The United Nations Population Fund (UNFPA) global research released on 28th April 2020 suggests that for every 3 months a COVID-19 lockdown continues, an additional 15 million extra cases of gender-based violence are expected around the world.[ix]

45. We know that some of our most vulnerable clients will be impacted by social-isolation and an inability to leave their homes to visit our clinics. Women's Aid have suggested that COVID-19 is becoming a way in which abusers will further control victims every move.[x] Controlling pregnancy and / or contraception is a method of control widely used by perpetrators of domestic abuse, over a third of domestic abuse begins or worsens in pregnancy.

46. Because of the pandemic, women who are in coercive, controlling relationships cannot leave home citing a non-essential reason. Previously, women could usually give a reason to leave the home for their abortion care appointments, such as taking children to school, going to work, seeing a friend. These options do not exist under self-isolation and social distancing measures.

47. Our Safeguarding Lead Nurse has had many cases bought to her attention during this COVID-19 crisis, including instances of young people struggling to leave their homes to attend the clinic. These young people would ordinarily use school, college or visiting friends as a reason to leave the home to obtain medication confidentially, but now have no option to do this.

48. Prior to the approval of an at-home early medical abortion service, by making clients leave their home to collect medication, we were being made to place many of them at a higher safeguarding risk for needing to leave the home, or equally at a higher safeguarding risk for continuing an unwanted pregnancy when leaving home was not possible.

49. We have seen many examples of this form of barrier to accessing care since the social distancing guidelines were introduced. One client was keeping the pregnancy a secret from her husband, whom she explained would not want her to have an abortion. The client was originally booked for a face-to-face appointment for a medical abortion, but kept missing her appointments due to social distancing guidelines, unable to leave her home without her husband being aware of situation. This would have been avoidable had we been able to provide mifepristone at home - in line with best practice - but in her case, this was illegal until the approval order was published.

50. Prior to the availability of at-home early medical abortion, we were contacted by a 19-year-old client. She became pregnant outside of marriage and she is at great risk of honour-based violence should her parents find out that she is pregnant. She has symptoms of COVID-19 and so could not come into a clinic for 2 weeks. This wait would mean that she can no longer access early medical abortion services, as her

gestation would indicate the need for a surgical abortion. Even after her two-week quarantine, she could not leave home safely as she would not be able to explain this to her family whilst social distancing is in effect. She is terrified of repercussions if her family find out. In cases such as these, the police must be immediately informed, and she must be safeguarded to receive the reproductive healthcare that she chooses.

51. Women living with domestic violence, who wish to end their pregnancy but are over 10 weeks gestation, will have no option but to attend a clinic for an abortion or continue a concealed pregnancy against their wishes. Both scenarios put women at risk of further violence and both the woman, and the infant if the pregnancy is continued, are urgent safeguarding concerns. This will only become more of an issue the longer the country is asked to continue with social distancing measures, as many women will be trying to hide pregnancies from their abusers until such a time that they can travel safely for a surgical abortion, all the while they risk missing the window for a legal abortion up to 24 weeks gestation.

52. Safeguarding can be conducted effectively over the phone. Whilst our teams are trained to develop a rapport with clients and have considerable skills and experience in face-to-face consultation, the initial feedback from them is that they are confident that safeguarding is equally effective, if not more effective through remote consultation. At the time of writing, we have surveyed 108 clients who have completed treatment through the telemedicine service and all of them reported that they had the opportunity to ask any questions or raise any concerns. All reported that they could talk privately during the consultation.

53. We perform our initial safeguarding checks during the first telephone contact with a client as standard. In the past few months this safeguarding protocol initiated multi-agency action in two major safeguarding cases, demonstrating that telephone assessment can be a powerful tool when used by experienced, trained teams. One involved the identification of a human trafficking ring, in which two clients were successfully treated and the police were able to rescue a number of women. Another identified a 12-year-old girl being abused by her step-father and step-uncle, with collusion from her mother. That child is now in safe care.

54. We have noted an increase in flagged safeguarding concerns since the social distancing measures, or “lockdown”, with a 21% increase in all safeguarding concerns during lockdown (Table 2) and a 15% increase in safeguarding concerns specifically linked to domestic violence (Table 1). All types of safeguarding concerns can include domestic violence, honour based violence, homelessness, child sexual exploitation, mental health issues, rape or sexual assault, modern slavery and reproductive coercion. Our robust safeguarding protocols continue to identify these issues over the phone as well as we would have in the face-to-face clinic environment.

Domestic Violence	**Safeguarding Concerns raised**	**%**
Before Lockdown 8th - 22nd March	90	15% increase
During Lockdown 23rd - 8th April	105	

Table 1: Domestic violence safeguarding concerns raised pre-social distancing and during social distancing.

All Types of safeguarding	**Concerns raised**	**%**
Before Lockdown 8th - 22nd March	629	21% increase
During Lockdown 23rd - 8th April	779	

Table 2: All safeguarding concerns raised pre-social distancing and during social distancing

55. These statistics and case studies show a clear need for increased safeguarding and social care support. There is an increased need for spaces within emergency refuges for those living with domestic violence who need to break away from their family to access abortion care, or for those who we identify as having been coerced into attending an abortion care appointment against their wishes.

Northern Ireland

56. The new abortion regulations in Northern Ireland, which commenced on 31st March 2020, do not permit taking the first early medical abortion medication, mifepristone, at home, only the second medication misoprostol. This would mean that any provision in Northern Ireland would still legally require the patient to physically attend the clinic at least once. This forces women in Northern Ireland to leave their homes unnecessarily, when the clear advice from the Department of Health, Social Services and Public Safety in Northern Ireland is to not travel or leave the home where possible.

57. Requiring women to travel to take mifepristone in a clinic setting is not medically necessary and is contrary to NICE and RCOG abortion guidelines. It also creates inequity between women living in Northern Ireland and women living in other parts of the UK, as England, Scotland and Wales have all permitted full at-home early medical abortion during this pandemic.

58. For those who are at higher gestations or have complex medical needs and require more specialised surgical abortion care, women in Northern Ireland have few options but to travel to England for care. If public transport services are running a skeleton service and flights are regularly cancelled, many women will find it difficult or impossible to reach the clinics. There have been reports of women using overnight freight ferry services to travel from Belfast to Liverpool, a journey that takes 8 hours. Others are nervous about travelling a long way on public transport with the increased risk of contracting the virus.

59. Privacy is also a serious concern for those who need to travel from Northern Ireland as women may be forced to disclose highly confidential information to justify why they are breaking lockdown to travel. As noted in the section on domestic abuse and safeguarding, this is especially difficult for vulnerable women who are young, or who have a controlling or violent partner. Prior to the pandemic and social distancing measures, many travelling for care were able to keep their reasons for travelling to England private, by citing a shopping trip or city break plans. This is no longer an option in the current pandemic and will act as a further social barrier to accessing care.

60. Until recently, those living in Northern Ireland were already facing inequalities due to the restrictive abortion law. Where legal, regulatory, social or economic restrictions exist due to the pandemic and / or measures to prevent the spread of COVID-19, the UK governments must make every effort to remove them and ensure universal access across the UK. Surgical abortion provision in Northern Ireland must be assured for those who need to access care and mifepristone must be authorised for home-use in line with England, Scotland and Wales.

Recommendations: Which could be acted on in 3 weeks' time

61. Ensure that Clinical Commissioning Groups across the UK allow any registered, qualified abortion provider to care for patients during this time of COVID-19 crisis response in line with the NHS constitution where a choice of provider is guaranteed when waiting times are being breached.

62. Amend the home use of mifepristone and misoprostol approval order to be in line with that of Scotland so that the arbitrary gestation limit for access to early medical abortion is removed. The decision for what treatment is most appropriate should be one based on an informed choice of the client following the evidence-based advice of her clinical team, not one forced through legislation.

63. Authorise nurses and midwives to prescribe abortion medications and certify the legal grounds for an abortion to strengthen the essential abortion care health systems against doctor absence and to avoid delays to care.

64. Remove the need for two doctors to certify the grounds for an abortion, permitting one registered medical professional (doctor, nurse or midwife) to certify the legal grounds for a requested abortion in good faith, to strengthen the essential abortion care health systems against doctor absence and to avoid delays to care.

65. Urgently provide additional emergency refuge spaces during this pandemic to accommodate the increase in domestic violence concerns identified at abortion care services, to allow for survivors of domestic abuse to safely attend abortion appointments without fear of intimate partner violence, and as a safe place for those we identify as being coerced.

66. Urgently authorise mifepristone for at-home use in Northern Ireland, to allow for a full at-home early medical abortion service via telemedicine, in line with best-practice and provision in Scotland, Wales and England.

67. Ensure that surgical abortion services are available in Northern Ireland for those post 10 weeks gestation in order to prevent the need for women to travel by plane or ferry to attend appointments in England.

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End Notes

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