UK Government: Early medical abortion at home - consultation

Response from MSI Reproductive Choices UK

Who we are

MSI Reproductive Choices is a global organisation with nearly 11,000 team members working in 37 countries to deliver reproductive health services.

We are one of the world's largest providers of high quality, affordable contraception and safe abortion services. In the UK we provide 30% of all abortions for the NHS in England. We also operate a 24-hour contact centre, One Call, where clients can make enquiries, book consultations, counselling and abortion care appointments, and speak to a nurse for aftercare advice.

Our consultation response

Summary of our response and recommendations

MSI Reproductive Choices UK (MSI UK)'s experience of providing telemedicine in England has shown the current arrangements to be safe, convenient, accessible and to have reduced waiting times.

We strongly recommend abortion via telemedicine is kept as an option after the COVID-19 pandemic is over. Indeed, the body of evidence in favour of telemedicine is now so robust that it is difficult to see how removing this option could be justified on clinical or scientific grounds.

Key points:

- Our research and experience found **no evidence** to suggest that telemedicine increases significant adverse events (which we define as ectopic pregnancies, haemorrhaging requiring transfusion, infection requiring hospital admission, major surgery, or death).

- **Mifepristone is an extremely safe drug**; there is no clinical or scientific rationale for restricting its use to clinical locations only.

- There have been **no deaths or serious incidents** for any MSI UK clients (nor, as far as we know, for any other provider's patients) as a result of telemedicine.

- There is **no clinical requirement for every single person seeking an abortion to have a scan**; this is not a requirement for those continuing with a pregnancy, and there is no clinical reason why those who choose abortion should be treated differently. It has also never been recommended in any clinical guideline nor been required in any regulation.

- In Scotland, **there is no mandatory 10-week limit**; clinicians are trusted to agree the best abortion pathway for each patient on a case-by-case basis. This approach allows clinicians and patients to consider medical needs and personal circumstances. Clinicians must be able to act in the best interests of their patients. **We recommend removing the 10-week limit in England.**

- There are **robust safeguarding measures in place for telemedicine abortion**, and indeed telemedicine is preferred by and safer for many of our most vulnerable clients, including those in abusive or coercive households, and those who are marginalised on account of one or more protected characteristic.

- We are **not recommending that telemedicine completely replace the non-telemedicine pathway**; it is very important for multiple reasons that there is a **choice of methods** available, depending upon what is right for each person clinically, logistically, and emotionally.

1. Question: 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?

Our answer:

a) Yes, it has had a positive impact.

Comments (optional):

MSI UK's experience of providing telemedicine in England has shown it to be safe, convenient, and to reduce waiting times. The current arrangements have had a positive impact on safety, accessibility, convenience, and on waiting times.

Safety

Early Medical Abortion at Home (EMA), whether provided by telemedicine or not, is only available to clinically eligible patients. The design of the telemedicine pathway is fully aligned with guidance from the National Institute for Health and Care Excellence (NICE), the Royal College of Gynaecologists (RCOG) and the Royal College of Midwives (RCM).

Our trained advisors hold a telephone consultation with each patient, and then decide on the most suitable pathway. If there are any clinical risks (such as signs of an ectopic pregnancy or lack of certainty around gestation), the patient is referred for a detailed in-person assessment. Making telemedicine available also doesn't stop patients from choosing face-to-face consultations or surgical abortion.

Clinical safety

Abortion is a common and safe procedure. Serious incidents, events or complications are rare whether the patient is treated by telemedicine or not.

As explained in the research paper *Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine* (*British Journal of Obstetrics & Gynaecology*, 2021, Dr Abigail Aiken, Dr Patricia A. Lohr, Dr Jonathan Lord, Dr Nabanita Ghosh, and Dr Jennifer Starling) we found no evidence to suggest that

telemedicine increases significant adverse events. We define 'adverse events' as ectopic pregnancies, haemorrhaging requiring transfusion, infection requiring hospital admission, major surgery, or death.

In fact, the aforementioned study found a small reduction in cases of haemorrhages requiring transfusion, with 0.08% of patients treated via the non-telemedicine model experiencing it, and only 0.04% of those patients treated with telemedicine. No cases of significant infection requiring hospital admission, major surgery or death were reported. The sample size for this study was 52,142.

Effectiveness

The minor increase in effectiveness outlined in the study published in BJOG (as above) could be because it is easier for the patient to take the medicines at the correct interval when this is done at home. When clinic days for taking mifepristone are fixed, there can be access challenges such as parental, caring or work commitments. If the medicine is taken at home, however, there is more flexibility while remaining within the correct medical timeline.

Lower gestation rates

The speed and accessibility of the service has reduced the average gestation time at which abortion is carried out. The evidence shows that early abortion is safer and generally preferred by patients. *Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine* compared the telemedicine pathway with the previous pathway and found that 40% of abortions via telemedicine were provided at six weeks' gestation or less, compared to 25% via the non-telemedicine pathway.

Note that the correlation between the lower gestation rates and accessing the abortion via telemedicine has an extremely low p value (<0.001); we are confident that this is a genuine correlation as a result of improved access. Abortions carried out via telemedicine were also more effective than non-telemedicine in this study, with an effectiveness rate of 99.2% for the telemedicine pathway, compared with 98.1% for in-person care. (The p value here is $p<0.001$.)

Ectopic pregnancy

Concerns have been expressed about abortion without a scan, fearing that this could increase the risk of ectopic pregnancies. From all the evidence available, these concerns appear to be without basis.

If the patient wasn't choosing to end their pregnancy, ultrasound would not be used to screen for an ectopic pregnancy unless the patient was experiencing specific symptoms. Guidance from RCOG and the World Health Organisation (WHO) says that routine scanning as part of the abortion pathway is not clinically necessary. Indeed, routine screening during pregnancy can result in a high false positive rate, and scans in these circumstances may cause unnecessary distress.

Rates of ectopic pregnancy are low. Around 11 in every 1000 pregnancies are ectopic, according to RCOG's *Diagnosis and Management of Ectopic Pregnancy*, but the rate in those requesting an abortion is ten times lower. As set out in *Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine*, neither the rates of ectopic pregnancy, nor the management of ectopic pregnancies differed significantly between the new telemedicine pathway and the old one.

There is no clinical reason why a patient who wants an abortion should be forced to undergo a scan while an individual wishing to continue their pregnancy does not.

Safeguarding and coercion

In addition to improving clinical safety, telemedicine has also made abortion safer for people with safeguarding risks (for example, if they are living with an abusive partner who may coerce them into or out of having an abortion). The ability to access pills by post has meant that it is much easier for many vulnerable people to have an abortion without putting themselves in danger by leaving the house to attend a clinic in person. Our experience has been people in coercive relationships are usually able to find ways of talking privately on the phone. However, if accessing abortion meant that they would need to attend a clinic in person, they would have to explain the reason to their partner – and some would be dependent on their partner for transport.

MSI UK runs One Call, a 24-hour phoneline, which offers advice before, during and after the abortion process. One Call's Safeguarding data covers concerns identified before the patient reaches the clinic (i.e. prior to any face-to-face assessment). We also run an online interactive tool which allows patients to access information or advice confidentially, at any time. Both tools follow the One Call Safeguarding Escalation Process, whereby any patients identified as a safeguarding risk are escalated to the One Call Safeguarding Lead, followed by an immediate strategy meeting to agree the next steps. As with any other service pathway, when providing care via telemedicine we continue to work alongside key partner agencies such as the police, social services, midwifes, GPs, school nurses, health visitors and other non-profit organisations to ensure that all patients and those around them (with particular emphasis on vulnerable children in the home) are safeguarded.

During the patient's consultation, our trained health advisors do not only establish clinical eligibility for EMA in general, and for telemedicine specifically; they are trained to check for any warning indicators of a safeguarding risk. If there are any such risks, they escalate the case accordingly. For example, patients are asked questions such as: "Are you safe to pass the pregnancy at home?" and "Are you safe to receive information and medications via post?" If the patient is not safe to do either, they may be deemed not eligible for telemedicine.

Safeguarding risks may be identified through these calls reactively, with a patient expressing fear or asking for help, or proactively, with the health advisor recognising that something is wrong. As part of the process, a safeguarding proforma (adjusted specifically to suit the nature of the appointment) is completed. Our health advisors are trained to recognise indicators such as a patient's tone of voice, or certain types of background noise, and to understand how these sounds can be indicative of the type of home environment that person is in. Examples include speaking very quietly (which can suggest the patient doesn't have support at home as their family or partner are not aware of the termination); shouting in the background (which may indicate an abusive household); and echoing where the call is on loud speaker or other voices that appear to feed information to the patient (these signs could suggest coercion). Our teams are trained to spot these signs; being present in a patient's home environment, even just via phone, can potentially tell us more about a patient than if they had attended one of our centres.

Before telemedicine was introduced, we had examples of our non-clinical telephone booking agents safeguarding individuals from a simple 10-minute booking call. Two notable cases include successfully safeguarding three human trafficking victims and a very young person who had suffered sexual abuse from family members for years.

By the end of November 2020 (after telemedicine had been in place for eight months), the number of safeguarding concerns identified through One Call had risen from 5,114 in 2019, to 6,259; given as a proportion, this represents 22% of patients in 2020, up from 16% in 2019. This shows that we have robust safety nets in place to identify safeguarding concerns without face-to-face contact, and before treatment is provided. (The reasons for this increase are complex but it has been well-documented elsewhere that the

pressures and restrictions of lockdown have impacted upon the safety of vulnerable people in abusive or unsafe households.)

Deaths

There have been no deaths or serious incidents for any MSI UK patients (nor, as far as we know, for any other provider's patients) as a result of telemedicine.

Pain

Although pain is not necessarily an issue of safety, we acknowledge that a feeling of being unable to manage pain can cause great distress, and lead people to feel unsafe – or make it difficult to identify any potential safety issues should they arise.

In the survey detailed in *Acceptability of no-test medical abortion provided via telemedicine: analysis of patient-reported outcomes*, published by the British Medical Journal Sexual & Reproductive Health (BMJ-SRH) we found that 87.9% of telemedicine patients were able to manage their pain at home "effectively", and a further 8.3% said they were able to manage it "somewhat effectively". 85.6% were confident that the abortion has been successfully completed, at the time of receiving the follow up call (approximately five days after the second stage of early medical abortion) although the feedback was collected before the recommended follow-up of a low sensitivity pregnancy test after three weeks.

According to the same feedback survey, 87.4% of the sample told us that they had no safety concerns about taking the medicines by themselves at all. 92.4% of telemedicine patients in the sample said they "definitely" had enough information to take the medications by themselves, while 5.5% told us they "somewhat" had enough information and 2.2% said they did not have enough information. Free text comments from the survey showed that where patients felt the need for more information, it was regarding general clinical concerns relating to the early medical abortion process, rather than concerns about taking the medicines at home through telemedicine specifically. For example, some patients said they would have liked more information about how much pain or bleeding they should expect. Most of these queries were resolved with relative ease, either by speaking to a nurse, by contacting the One Call helpline, or by using the online aftercare resources.

Impact on informal abortion provision

In Britain, the number of people accessing abortion pills from informal sources, such as online, has dropped since telemedicine was introduced. In European countries where there has been no telemedicine available, the opposite has happened during the pandemic; there has been a major increase in accessing abortion pills informally, as shown in *Demand for Self-Managed Online Telemedicine Abortion in Eight European Countries During the COVID-19 Pandemic: A Regression Discontinuity Analysis*. (Pre-print only, by Abigail R. A. Aiken, Jennifer E. Starling, Rebecca Gomperts, James G. Scott, Catherine E. Aiken).

While not all medicines purchased through less formal channels are unsafe, the safest way to have an abortion is through a formal, regulated provider. This is not only because of the assurance around the quality of the medicine itself, but also because there are opportunities for a regulated provider, with staff trained in spotting vulnerabilities and risks, to identify any additional needs (such as safeguarding, contraceptive, or counselling needs) and make sure the patient gets appropriate follow-up support if needed or wanted. It is therefore reasonable to view the reduction in informal abortion provision as an indirect positive policy outcome.

2. Question: 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?

Our answer:

a) Yes, it has had a positive impact

Comments

As set out in the paper *Acceptability of no-test medical abortion provided via telemedicine: analysis of patient-reported outcomes*, when telemedicine patients were asked about their preferences for any future abortion care, should they choose an abortion again at some point, two-thirds (66.3%) said that they would prefer telemedicine even if COVID-19 was not a factor.

The main reasons given for this preference were that it is more comfortable, more private, more convenient, quicker, and easier. Note that "free-text" comments from the survey prompted many positive comments that related to accessibility, such as the ability to manage their abortion around work, childcare, and other commitments.

Medicine delivery and collection

MSI UK telemedicine patients have a choice about whether they want to collect their medicines, or whether they prefer home delivery. For some, collection is more accessible (for example, if the patient lives very close to a clinic), and for others, home delivery by post is more accessible. Having a choice about as many aspects of the service as possible has meant that the service is flexible to suit individual patient needs.

Acceptability of no-test medical abortion provided via telemedicine: analysis of patient-reported outcomes showed that 31.5% of telemedicine patients preferred to collect their medication from a clinic, with 68.1% choosing to receive it by post. Of those receiving medications by post, 88.2% told us they had no concerns about accessing the medications in this way.

Equalities and accessibility

Childcare and other caring responsibilities

Flexibility is one of the great benefits that telemedicine offers. Through the feedback survey as shown in *Acceptability of no-test medical abortion provided via telemedicine: analysis of patient-reported outcomes*, MSI UK patients deeply valued the option of abortion medication by postal delivery, partly to minimise COVID-19 risks, especially when they had caring responsibilities. One of the most common reasons given for choosing postal delivery, and for expressing an overall preference for telemedicine was being able to manage the abortion around childcare, caring or family commitments.

Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain (*Contraception Journal,* by Abigail R.A. Aiken, Katherine A. Guthrie, Marlies Schellekens, James Trussell, and Rebecca Gomperts) identifies similar "barriers to accessing care through the formal healthcare system". The study concludes that "a diverse group of women… prefer the privacy of conducting their abortions in their own homes," and recommends policy frameworks be developed to address the barriers that prevent abortion at home.

Below are examples of comments MSI UK has gathered from patients about their experiences with telemedicine. These comments show how our patients valued the flexibility and choice that telemedicine offers:

- "Everything was amazing, the support was amazing, I hope this carries on [as] it helps people like me with children."
- "Really valued being able to take medications at home because had additional stress at work and felt the whole experience was made easier. Give women more choice."
- "Really nice to have that choice – as a woman we should have the right to make our own choices and it's harder to talk face-to-face than over the phone"
- "After this experience, [I] would choose this option again, private and comfortable in my own home. The nurse was very informative and reassuring"

Geography and transport

We know that in rural areas, especially deprived parts of the country without reliable public transport, telemedicine has improved abortion access, particularly in terms of waiting times, as patients who would previously have to make extensive preparations to travel to a clinic can now access fully remote care quicker.

Waiting times

Telemedicine abortion has reduced waiting times. *Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine* explains that waiting times were 4.2 days shorter on average for patients within the telemedicine pathway. A reduction in abortion waiting times not only enhances the patient experience by improving convenience and access, but can also positively impact clinical outcomes, because earlier abortions are the safer.

10-week limit

The 10-week limit creates a barrier to access. MSI UK supports the Scottish approach on the 10-week limit, whereby clinicians are trusted to make the decision about the best abortion pathway with their own patients on an individual basis, taking into account the patient's personal complexities and needs. The 10-week threshold in England appears arbitrary and without clinical foundation.

Acceptability and satisfaction

Overall, 98.1% rated their experience good or very good and only seven patients (0.6%) reported their experience as poor or very poor. 83.3% of patients said they would not have preferred a face-to-face appointment during the pandemic, as the telemedicine pathway suited them. Only 16.7% told us they would have preferred a face-to-face pathway for this abortion or that they were not sure.

However, it is important to emphasise that we are not recommending that telemedicine completely replace in-person pathways; these are vital to ensure continued access to surgical abortion, and for individuals who want or need in-person support with medical abortion. It is right that for multiple reasons that there is a choice of methods and pathways that are flexible depending upon what is right for the individual clinically, logistically and emotionally.

3. Question: 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?

Our answer:

a) Yes, it has had a positive impact

Comments (optional)

MSI UK patients receiving routine follow-up calls reported high confidence in telemedicine abortion, and high satisfaction with the privacy, convenience, and ease of this pathway. As described in our answer to Question 1, we have found that telemedicine has improved privacy and confidentiality for patients.

As set out in the paper *Acceptability of no-test medical abortion provided via telemedicine: analysis of patient-reported outcomes,* between April and August, among a sample of 1,243 telemedicine patients contacted for feedback, we found that 95.3% of patients were able to talk privately during their consultation. 4.6% of patients surveyed had to make some arrangements before they were able to have the call in private, such as organising childcare or going outside to sit in the car. Only 1 patient surveyed (0.1%) indicated they had to be careful about privacy during their consultation, and no patient reported that they were completely unable to talk privately. In addition, 99.3% said they felt able to ask questions during their consultation, a key marker of good quality of care.

In "free text" observations given during the feedback call, there were no comments suggesting any pressure or coercion. Indeed, many patients said they preferred having the consultation over the phone because it removed the stress or judgment of visiting a clinic in person.

There can be privacy and confidentiality challenges inherent in visiting a clinic in person, especially for patients living in a smaller community, where they may see people they know as they are entering the premises. There are often anti-abortion groups gathered outside clinics, mainly targeting women and girls. These groups have been known to take photographs or film people outside the clinics. The ability to receive abortion medicines at home in discrete packaging means that patients can avoid this type of harassment, which infringes upon their reasonable expectation of privacy.

It can also be difficult to leave the house without anyone the patient lives with knowing why. This is especially challenging for patients who are dependent upon others for transport, and younger patients who live with parents or carers, or those with caring or work responsibilities they need to manage. Even as the pandemic comes under control, and COVID-19 restrictions will be eased at varying paces, working and studying from home is likely to remain common among many, which means it will continue to be extremely noticeable in many cases when someone leaves their house. Removing the option of telemedicine would therefore make it much more difficult (and in some cases, impossible) for these patients to maintain privacy around their abortion.

4. Question: 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.

Our answer:

a) Yes, it has had a positive impact

Telemedicine has been hugely beneficial for those providing abortion services.

Telemedicine allows nurses to spend more time with the patients who really need it, which is important for delivering the best possible care, and for professional morale. Telemedicine consultations often take longer than in-person consultations. Our team members report that patients seem able to talk more freely and openly. Abortion can be an emotive subject with considerable stigma; sadly, patients often expect to be judged. When forced to attend a clinic, they are therefore more likely to be defensive and answer questions in the way they think is expected.

With the telemedicine pathway, resources are not wasted on fulfilling arbitrary requirements (for example, mandatory scans for every single person seeking an abortion).

There are also workforce benefits from telemedicine, in that it enables clinicians to work from home. 58% of MSI UK early medical abortion doctors have children. The ability to work from home allows for greater flexibility in childcare arrangements, while also working efficiently and effectively. Home-working also removes a (sometimes costly) commute, and boosts work-life balance.

Home working can also be beneficial for doctors with health conditions, both of a long and short-term nature. For example, when a doctor has a viral illness where onward transmission must be prevented, or a physical injury which prevents them travelling into work, they may still be well enough to work at home. The ability to work from home would strengthen workforce resources by reducing sick leave, and boosting service resilience, especially during high-risk periods such as flu season.

For example, one of our early medical abortion doctors with long-term health problems reported to us that working from home specifically helps them stay in work, which is then in itself beneficial to their mental and financial wellbeing. Be retaining telemedicine, we will be able to broaden the group of doctors able to work for the service, who may not be able to work in other clinical roles.

Over 50% of our early medical abortion doctors currently work in other NHS roles, and they have given feedback that working from home has helped them maintain their mental and emotional wellbeing by supporting a healthier work-life balance.

Telemedicine has also allowed some providers to better direct their resources where they are most beneficial for patients. Examples include repurposing clinical spaces which are no longer needed so they can be used for the provision of vital services such as Long-Acting Reversible Contraception (LARC).

All of these benefits directly improve retention and recruitment of clinical staff. This is vital at time when the country faces many difficulties around maintaining our clinical workforce, which can have a significant impact on other healthcare services too.

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

Our answer:

a) Yes, it has had a positive impact

Comments:

There is a long-term impact on the wider health and social care system if people are unable to access abortion. Pressures have been eased on NHS providers because telemedicine has been efficient.

There is a long-term benefit for the wider NHS and social care system in improving retention and recruitment of a clinical workforce, which is directly related to telemedicine, as explained in our answer to Question 4.

6: Question: 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?

MSI UK supports the Scottish approach on the 10-week limit, whereby clinicians are trusted to make the decision about the best abortion pathway with their own patients on an individual basis, taking into account the patient's personal complexities and needs. We view the 10-week threshold in England as an arbitrary barrier without clinical foundation which prevents clinicians from acting in the best interests of their own patients.

MSI UK designed its telemedicine pathway carefully to ensure maximum patient safety, with risk mitigations built in. This involves giving key information to patients at each stage of the process.

There is a low risk that patients could be mistaken about the gestational age of their pregnancy. Using the patient's Last Monthly Period (LMP) as an indicator of gestational age is broadly reliable. When human error does occur, it may be found that a pregnancy is further along than was initially believed. However, the most significant risk is not a clinical one, as it is highly unlikely that there would be medically significant consequences. Indeed, self-managed abortions at >12–24 weeks' gestation have a success rate of 93%, which is very similar to the rate for earlier gestations. (See *Complications of Unsafe and Self-Managed Abortion*, Lisa H. Harris, M.D., Ph.D., and Daniel Grossman, M.D., *New England Journal of Medicine*).

Patients' possible pathway options are limited by the 10-week limit, and in rare cases where abortion at home might be the most appropriate treatment after 10 weeks, the clinician should be able to discuss the options freely and fully, rather than force the patient to attend a clinic to take mifepristone and misoprostol at potentially great inconvenience, or even personal risk.

There is a risk to the patient, however, that in making such a mistake about gestation dates, a patient who has caused no harm and has no intention of causing harm could be subject to punitive consequences, or even criminalisation. It is right that in Scotland the time limit for medical abortion is not arbitrarily restricted; MSI UK supports this flexibility as it allows clinicians to act in the best interests of their own patients.

As we have said, the best mitigation for the above risk would be to remove the 10-week limit altogether. If an arbitrary limit is retained, the best way to mitigate the risk is to ensure it is strongly emphasised to all involved in managing patients following an abortion that they should be supported, and not judged or criminalised in the event of a mistaken gestation date.

7. Question: 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?

Abortion is a safe procedure, whether provided via telemedicine or not, and risks are low. Mifepristone is a very safe drug, and there is no clinical reason why it should be taken within a clinic or hospital. There are disadvantages to forcing patients to make a visit to a clinic.

As we have set out in our answer to Question 1, our experience and research indicates that there are disadvantages to forcing patients to visit a clinic. It is difficult to leave the house without the people you live with finding out why.

There are also privacy concerns associated with the anti-abortion groups outside many clinics. In addition to harassing patients as they enter or leave clinics, these groups have been known to film or photograph patients. This can be particularly traumatising for many patients, particularly those who have experienced rape or domestic abuse, and it is very dangerous for patients with a risk of repercussions, such as so-called "honour violence."

Some patients tell us find it easier to speak freely over the phone or by video. Abortion can be an emotive subject with considerable stigma; sadly, patients often expect to be judged. When forced to attend a clinic, our team members tell us patients are more likely to be defensive and answer questions in the way they think is expected, whereas on the phone they tend to speak for longer, and more openly. Our One Call team is also fully trained and available 24/7.

There are no benefits to forcing every patient to attend a clinic in person regardless of circumstances, and there are serious disadvantages. A one-size-fits-all service model is not suitable for such a complex, specialist service as abortion.

Ultimately, this is about choice. People have different personal circumstances, and the safest approach, from both a clinical and a safeguarding perspective is to allow each patient to agree the access route which is right for them together with their clinician.

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?

- **Yes**
- No
- I don't know

If yes, please outline possible impacts below. Please be as specific as you can and include any resources or references to evidence on this topic that we should consider.

Patients with protected characteristics and other vulnerable groups

The availability of early medical abortion at home has had a positive impact on "equalities groups." For example:

Sex

Sex is a protected characteristic. Abortion has long been stigmatised because it is a service associated with women's sexual activity. Much of the anti-telemedicine rhetoric is rooted in an assumption that women are unable to accurately know their own LMP, unable make their own medical decisions, are unable to effectively cope with pain, and are unable to know their own best interests.

Telemedicine provides greater dignity, privacy, safety and choice for all our patients, the majority of whom are women. For example, when forced to take the second dose of medicine in a clinic setting, the pregnancy may be passed during the patient's journey home, which could be on public transport. This is

degrading, painful, and since the government has allowed abortion pills to be taken at home, unnecessary unless the woman is over 10 weeks' gestation. Indeed, when the government first allowed misoprostol to be taken at home, objections were raised which are similar to the objections we see now in relation to telemedicine. None of the concerns expressed back in 2018 about home use for misoprostol have come to pass.

There is no clinical or safety justification for mifepristone to be taken in a clinic. It is a safer drug than many non-prescription medications which people are trusted to use unsupervised, including paracetamol; it is hard not to conclude that the restriction is based on historic discrimination of women that conflicts with the protective characteristic of sex.

Note that the accessibility benefits of telemedicine for those with caring responsibilities, could also be considered an indirect beneficial impact on women, as women disproportionately hold these responsibilities.

Age

At MSI UK, the rates of under 18-year-olds accessing abortion has risen slightly in the past year. The personal stories we receive through our patient contact and through our safeguarding team strongly indicate that these are young people who may not be able to get to a specific clinic location for an abortion (for example, if they are dependent upon parents for transport), and as a consequence, without telemedicine, could become child or teenage parents when they do not want to be. Our findings do suggest that there could be a minor correlation between being aged under 20 years and expressing a preference for a face-to-face pathway. As always, we reiterate that we recommend telemedicine remaining in place as an option, but that patients continue to be given a choice of pathway to accommodate personal needs.

Our online access tool has been invaluable in providing young people with confidential advice and support, and telemedicine has made it easier for these patients to get the care they need.

Case studies include the story of a 14-year-old girl, whom we shall call B. B contacted MSI UK through our online chat tool to explain that she had become pregnant, and she didn't want to be. She shared a room with her sister so she could not speak on the phone, and she could not leave the house without her mother finding out, which she did not want to happen.

The online chat tool allowed B to express herself in her own way (for example, using emojis) and in her own time, with safeguarding professionals taking great care to protect B's safety. The team at MSI UK was able to build trust with B by also communicating with emojis and working in a flexible way. This included ringing B back at agreed times, never saying where they were calling from until they had confirmation that it was okay to do so and recognising that B sometimes needed to end a call promptly if there was a privacy concern.

The combination of telemedicine and the online chat tool allowed B to terminate her pregnancy in privacy and with dignity, instead of having to attend a clinic in person, or continue a pregnancy she did not want at the age of 14. MSI UK could also draw upon our safeguarding resources in providing her care, which would have been denied to B had there been no other option than to seek illicit sources.

Disability access

There can be access barriers for disabled people in attending health services in person, and abortion is no exception. If a patient can manage their abortion in their own home, especially for a procedure as time

sensitive as abortion, then this option should always be available for anyone who wants it, unless there is a clinical reason not to do so.

There is also evidence that disabled people are twice as likely to experience sexual assault, domestic abuse and stalking than non-disabled people. (*Disability and domestic abuse topic overview*, Public Health England). As telemedicine is usually the safest option for domestic abuse survivors, there is arguably an indirect benefit to this service for disabled people in abusive households who want an abortion as well.

Avoiding anti-choice protesters

Anti-choice protesters often target those accessing an abortion clinic in person. They attempt to intimidate patients by handing out false information, praying, shouting, telling people they will go to hell, making threats, taking photos, and even at times barricading clinic entrances to prevent access altogether, as documented during the public consultation process for the introduction of Public Spaces Protection Orders in Ealing and Manchester.
This behaviour goes beyond free speech and peaceful protest (which, as a pro-choice organisation, MSI UK passionately defends). It strays into targeted harassment, and misinformation. While it can be distressing for any of our patients to be on the receiving end of this treatment, it can be disproportionately distressing for women of colour, religious women, teenagers, trans or non-binary patients, and disabled patients. Even silent protests, such as praying or staring, can be deeply upsetting and intimidating to vulnerable patients, such as those with mental health problems.

Telemedicine allows patients to have an abortion in private without facing harassment, intimidation, or risks to their privacy. Two case study examples are below.

- Case study one: The patient was worried that their parents would find out about the Termination of Pregnancy Service (TOPS), and said she was scared. When asked if she was safe to receive medications through post, she assured the team that she would not be in physical danger - but the patient said she was worried about being shunned from her family. The patient said they felt safer receiving medications by post. MSI UK talked her through exactly what the package would look like and when she was likely to receive it, so that she could receive her medications safely and complete the abortion safely.

- Case study two: MSI UK booked a telemedicine appointment for the patient. Initially, the patient said she was safe to speak. However, when the MSI UK team member asked the safeguarding questions about so-called “honour-based” violence, the patient said her family didn't know – and that she didn't know if they would hurt her if they found out. The patient told MSI UK that her big brother “would not accept it.” When asked if anyone had physically hurt her, she answered “not really” (as opposed to “no”), although when questioned further, she eventually said no. The patient was invited for a face-to-face appointment the same day, which she was happy to attend in person. This allowed the patient to speak privately, and for safeguarding protections to be considered in full.

These case studies show how unique each individual patient’s needs are, and that each patient should have the choice of a range of different pathways so they can choose the safest pathway for them.

Gender reassignment

Telemedicine has been beneficial for transgender men and non-binary people who choose an abortion. While we do not have survey responses at MSI UK broken down by gender identity, we do know from

patient feedback that the experiences of trans men accessing health care services generally associated with women, such as abortion are often reported to be painful, humiliating, or confusing. We also know that some transgender people do avoid accessing certain types of medical treatment in person, which can lead to LGBTQ+ health inequalities. For example, the *UK National LGBT Survey* reports that:

"40% of trans respondents who had accessed or tried to access public healthcare services reported having experienced at least one of a range of negative experiences because of their gender identity in the 12 months preceding the survey. 21% of trans respondents reported that their specific needs had been ignored or not taken into account, 18% had avoided treatment for fear of a negative reaction, and 18% had received inappropriate curiosity."

"Moreover, 7% had to change their GP, and 7% had faced unwanted pressure or being forced to undergo a medical or psychological test. By comparison, 87% of cisgender respondents who had accessed or tried to access public healthcare services had not faced any such negative experiences due to their sexual orientation in the 12 months preceding the survey."

Although MSI UK is proud of our commitment to creating dedicated pathways for transgender patients seeking abortion, and although we have training and support in place for team members to support all patients without judgement, it remains true that many transgender and non-binary people may continue to be understandably wary of judgement or mistreatment from health providers. Where this is the case, telemedicine offers safety, privacy and dignity for any transgender men or non-binary patients who choose an abortion but do not feel comfortable accessing these services in person.

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?

We know that travel is costly and difficult, and that it is real barrier for lower income individuals accessing care safely, confidentially, or comfortably. In some rural areas, transport to a clinic can take over two hours each way. The length of this journey is especially problematic due to the fact that the second stage of early medical abortion (misoprostol) may begin to take effect during the journey, and whilst this has been largely resolved since approval was given for use of misoprostol at home, it limits choice for those over 10 weeks. If complications or problems do arise during the patient's home abortion, the majority of these complications can be addressed through the 24-hour phone advice line delivered by specialist nurses.

In addition to travel costs, childcare is expensive, and many people cannot afford to take time away from work to travel for an abortion – especially as many people, quite understandably, may not feel comfortable explaining the reason to their employer.

Internal analysis of our clinical service data has found that the demographic profile of clients before and after the introduction of telemedicine is broadly comparable, indicating that the introduction of telemedicine has not disproportionately negatively affected access for any marginalised or vulnerable groups. We also found evidence that the overall reduction in waiting times after the introduction of telemedicine (which is a precise marker of ease of access to abortion care) has been most beneficial for patients living in the most rural and most deprived areas, overcoming previous inequalities in wait times for these groups.

We conclude from this, therefore, that telemedicine has certainly not worsened access for the most vulnerable and marginalised, and in fact appears to help equalise access to abortion for people living in geographically disadvantaged areas and for people living in social deprivation.

Whether to make current early medical abortion arrangements a permanent measure: As set out above, we are seeking views on whether the current flexibilities should be made permanent or not.

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

a) Become a permanent measure?

b) End immediately?

c) As set out in the current temporary approval, be time limited for 2 years or end when the temporary provisions of the Coronavirus Act 2020 expire, whichever is earlier?

d) Be extended for one year from the date on which the response to this consultation is published, to enable further data on home use of both pills for EMA and evidence on the temporary approval's impact on delivery of abortion services to be gathered?

e) Other [please provide details]?

Our answer:

a) Become a permanent fixture

MSI UK's experience of providing telemedicine in England has shown the current arrangements to be safe, convenient, accessible and to have reduced waiting times. We strongly recommend that telemedicine becomes a permanent fixture.

There is clear and robust evidence from MSI UK's own data as well as other published peer-reviewed research which shows that telemedicine is effective, safe, and acceptable method of delivery abortion care.

Telemedicine improves access to abortion while maintaining the same clinical outcomes as seen with in-person care, and in some aspects of care, improving safety (such as reducing the average gestational age). In addition to the evidence presented by MSI UK in response to this consultation, there is already a body of pre-existing evidence which fully supports home-use of abortion medication.

NICE recommends the provision of telemedicine, following a systematic review, and says that not only is telemedicine safe and acceptable, but that it should in fact be viewed as an improvement to abortion care.

Based on the evidence set out above, MSI UK cannot find any clinical or scientific reason not to maintain telemedicine as an option. Removing this option now would be to reinstate access barriers to an essential medical service with no clinical or scientific basis. It is difficult not to conclude that such a decision would be rooted in ideological or political motivations, including a sexist view that women cannot be trusted to know their own LMP dates, cannot be trusted to make their own decisions about health care, are not able to effectively manage pain, and are unable to know their own best interests.

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