Consultation Response Form

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Consultation questions

Q1.	**Do you consider that the temporary approval has had a positive impact on the provision of abortion services for women accessing these services with particular regard to safety, accessibility and convenience of services? Please provide your reasons.** **A. Safety – negative impact** The absence of a face to face consultation: 1) **removes the physical examination and routine scanning that would confirm gestation dates**. The 'pills by post' process relies on the woman being able to recall the first day of her last period. Studies report that approximately one half of women do not accurately recall their LMP.[1] Evidence from the DHSC[2] confirms that pregnancies that are well past 9 weeks and 6 days are being terminated at home, with increased safety risks, particularly haemorrhage, as a consequence. 2) **removes examination and scanning that would reveal if a pregnancy is ectopic** A ruptured ectopic pregnancy is a surgical emergency. For all women this is of serious concern, but for those living remotely it can be a matter of life and death. 3) **removes the opportunity to clarify and supervise the timing and method of taking the two medicines** For example, one of the pills (Misoprostol) is designed to be absorbed from the mouth by keeping the pill between the cheek and gum for a full

[1] https://www.healthcare.uiowa.edu/familymedicine/fpinfo/OB/OB2017/ACOG%20redating%20gestational%20age.pdf page 2.

[2] https://www.gov.uk/government/statistics/abortion-statistics-during-the-coronavirus-pandemic-january-to-june-2020

	30 minutes. Swallowing the pill whole converts it to an oral dose, which is associated with reduced efficacy and increased failure rates.[3] 4) **removes a safe place for a woman under coercion to speak freely**. Vulnerable women in abusive relationships may be forced into taking the abortion pills. 5) **allows impersonation** Is the woman requesting abortion the same woman that will take the medicines? A nationwide undercover investigation, commissioned by Christian Concern, showed that '*home abortion schemes are wide open to abuse*' and are '*leading to dangerous and illegal 'DIY' abortions.*' Kevin Duffy, ironically a former Global Director of Clinics Development at Marie Stopes International, who led the investigation, said: *'The investigation clearly demonstrates that abortion at home, by pills-by-post, is not safe and on many occasions oversteps legal boundaries without any proper scrutiny... It is deeply concerning that the abortion industry has been allowed to take this service this far during an already highly vulnerable time for pregnant women. The process of wholly relying on telemedicine must be withdrawn urgently.*'[4] 6) **removes the opportunity to check that the patient has another adult present who will raise the alarm if things go wrong, and that emergency medical support is at hand.** Manufacturers clearly understand these risks: the data sheet supplied with Medabon's 'Combipack' of Mifepristone with Misoprostol states: *"Because it is important to have access to appropriate medical care if an emergency develops, the treatment procedure should only be performed where the patient has access to medical facilities equipped to provide surgical treatment for incomplete abortion, or emergency blood transfusion or resuscitation during the period from the first visit until discharged by the administering qualified medical professional."*[5] A Swedish study which looked at all abortions from one hospital from 2008 to 2015 reported an overall complication rate of 7.3% in medical

[3] Scottish Abortion Care Providers Network. Abortion − improvement to existing services − approval for misoprostol to be taken at home. Scottish Government Health and Social Care Directorates 26 October 2017. https://bit.ly/2DFZi7y; Raymond EG et al. First-trimester medical abortion with mifepristone 200 mg and misoprostol: a systematic review. Contraception 2013; 87:26-37 https://bit.ly/2S10BRF ; Winikoff B et al. Two distinct oral routes of misoprostol in mifepristone medical abortion: a randomized controlled trial. Obstetrics and Gynecology December 2008;112(6):1303-10

[4] https://christianconcern.com/news/undercover-investigation-exposes-diy-abortion-service-breaking-the-law/

[5] Electronic Medicines Compendium (accessed 10.02.2021). 2020 [cited; Available from: https://www.medicines.org.uk/emc/product/3380/smpc

	abortions under 12 weeks. The commonest complication was incomplete abortion.[6] A significant finding was that the rate of complications associated with medical abortions increased from 4.2% in 2008 to 8.2% in 2015, **possibly associated with a shift from hospital to home medical abortions**. 7) **removes an opportunity for reflection – time to consider options in a non-pressurising context.** The BBC reported[7] concerns in Wales over the negative impact on women's health of not being able to access in-person abortion counselling. A study of women from Sweden who had home abortions in 2016 noted that 'one-third of the women stated that they lacked information in different areas like bleeding, pain, the abortion process, expulsion of the embryo, **and the opportunity to see a counsellor**. Lack of or insufficient information about bleeding was most frequently mentioned.'[8] Home abortion instructions given by phone or video are more likely to be misunderstood and therefore carry greater potential for harm. This would be especially true if the woman did not have English as a first language. 8) **increases the risk of psychological trauma** The American Psychological Association's report[9] identified fifteen risk factors for post abortion psychological injury, including suicidal ideation. Reardon notes that the list is one of the shortest that has been developed,[10] emphasising how unlikely it is that consultations done by phone or video link will be able to fully assess the risk of an abortion to a woman's psychological health. About half the women who have abortions in England and Wales each year have had at least one abortion previously. The incidence of repeat abortion is therefore high. Sullins found a compounding effect of repeat abortion on suicidal ideation and substance misuse.[11] 9) **allows abortions to be carried out without any record being kept**. Women can obtain NHS funded abortions at home without having to

[6] Carlsson I, Breding K, Larsson PG. Complications related to induced abortion: a combined retrospective and longitudinal follow-up study. BMC Womens Health 2018;18(1):158.
[7] https://www.bbc.co.uk/news/uk-wales-54423710
[8] Hedqvist M, Brolin L, Tyden T, Larsson M. Women's experiences of having an early medical abortion at home. Sex Reprod Healthc 2016;9:48-54.
[9] Report of the APA Task Force on Mental Health and Abortion. Washington DC: American Psychological Association; 2008.
[10] Reardon DC. The abortion and mental health controversy: A comprehensive literature review of common ground agreements, disagreements, actionable recommendations, and research opportunities. SAGE Open Med 2018;6:2050312118807624
[11] Sullins DP. Abortion, substance abuse and mental health in early adulthood: Thirteen-year longitudinal evidence from the United States. SAGE Open Med 2016;4:2050312116665997.

	apply through their GP. A direct approach to the abortion provider is possible. The provider is not obliged to inform the client's GP and the client can request that confidentiality be observed. As a result, the abortion may never appear on that patient's medical notes. Future care decisions may therefore be made in ignorance – this cannot be in the patient's best interests of safety 10) **prevents screening for sexually transmitted diseases (STDs).** The Royal College of Obstetricians and Gynaecologists (RCOG) recommends screening for Chlamydia and other STDs in all women having abortion.[12] This cannot be done other than by a face to face appointment. The lack of provision for this under the emergency provisions therefore increases further the risk of personal injury to the woman. 11) **entrusts safety into the hands of those whose practices have been found unsafe.** The Care Quality Commission found examples of malpractice at Marie Stopes centres in 2016. In answer to a Parliamentary question in February 2020, it was reported that 121 facilities performing abortions (59% of the total) required improvement for safety.[13] The proposal to make permanent the emergency regulations will lower safety standards. If abortion providers were already compromising on safety standards, then lowering those standards will likely result in further compromises. **A temporary measure to deal with an unforeseen national emergency should not become the norm. It is putting lives at risk.** **There has been no review by an independent body of the safety of remote consultations.** **The Welsh government has no systematic, objective data analysis of the outcomes for women post 'abortion at home', no evidence base for the safety of the process, no comparison with outcomes prior to the sanctioning of home abortion. Even if such an analysis existed, helpful as it would be, in such a short timeframe it would not cover longer term psychological consequences.** **Abortion providers should not be relied upon to provide unbiased data – remote consultations are clearly easier for them and cut costs.** **To press ahead with plans to make the emergency provisions permanent, without supportive evidence, appears driven more by ideology than science or public health concerns.**

[12] The care of Women Requesting Induced Abortion London: Royal College of Obstetricians and Gynaecologists; 2011.

[13] https://questions-statements.parliament.uk/written-questions/detail/2020-02-27/21971.

B. Accessibility – mixed impacts

Increased accessibility may be of benefit to those living in remote areas, but the greater speed and ease of access generally is not necessarily helpful. By 'streamlining' the process, the essential need for a period of calm reflection and access to non-directive counselling is denied. It is inevitable that this will lead to more women regretting decisions made in a hurry and without information and support.

If counselling is only offered by those agencies that are also providing the abortion, there is a significant risk of the advice being skewed by unconscious bias, especially with an ethically polarised issue such as abortion.

C. Convenience – negative impact

Decisions made hurriedly, in a time of anxiety or under pressure from others, are more likely to be regretted subsequently.
There is a drive to destigmatise and normalise abortion by presenting it as part of normal, routine sexual and reproductive health (SRH).[14] It assumes that prevailing sociocultural stigma is the primary reason for women feeling uncomfortable about having abortions. Our reflection would be that, after 50 years of abortion as commonplace in our society, we have to look for a better explanation of that discomfort. We suggest that it is every woman's natural intuition to offer a welcome in her womb as soon as she knows she is pregnant. To contemplate abortion flies in the face of that instinct and naturally provokes internal conflict. No amount of affirmation by SRH professionals is likely to offset this painful dilemma.
Making the process quicker and easier fails to recognise its significance as a life event and makes it more likely to lead to subsequent regret and mental health issues.

In their February 2019 Abortion policy statement, the Family Planning Association states: 'Free, non-directive pregnancy counselling and post-abortion counselling should be accessible to everyone who wants or needs it.'[15]
We appeal strongly for the mandatory provision of independent and non-directive information, counsel and support to be built into the process for all women considering an abortion. This should be followed by a 'cooling-off' period of at least 48 hours for reflection. This is one of the most important decisions any woman will make, with implications that will last her lifetime, not to mention the implication for her baby. Women facing such a decision should be able to access in-person support, information, and counselling in a setting free from coercive or commercial pressures.

[14] https://srh.bmj.com/content/47/1/32
[15] https://www.fpa.org.uk/sites/default/files/abortion-policy-statement.pdf

	This must not be left purely to abortion providers to supply; it has been amply demonstrated that those who profit from abortion cannot provide truly unbiased information and support.[16]

Q2.	**Do you consider that the temporary measure has had a positive impact on the provision of abortion services for those involved with service delivery? This might include greater workforce flexibility, efficiency of service delivery, value for money etc. Please provide your reasons.** **No, a negative impact** The overwhelming majority of healthcare professionals are highly motivated to deliver the best care possible for their patients. An induced abortion, even at an early stage, is a traumatic experience, emotionally as well as physically, even when it is without complication. Caring professionals will want to be alongside their patients at such times, and COVID-19 restrictions have prevented them from doing the best by their patients. This has caused healthcare professionals both frustration and injury to their personal moral intuitions. To perpetuate this one week longer than COVID-19 security necessitates would be harmful. Offering appropriate care and support will always trump 'service efficiency' for healthcare professionals.

Q3.	**What risks do you consider are associated with the temporary measure? If you consider that there are risks, can these risks be mitigated?** **1.The risk of discrediting government and undermining confidence in the democratic process.** In introducing the emergency provisions, the UK government relied on Section 1(3A) of the 1967 Abortion Act, a section that was added to the Act in 1990. At the time it was added, MPs raised concerns that this section could be interpreted as permitting self-administered home abortions. **They were assured this was not the case and that any such change would be for Parliament to decide**. Section 1(3A) was approved by Parliament on that understanding. In the event, Government introduced the emergency provisions while Parliament was in recess and following multiple assurances just days earlier that it would not happen. There was no opportunity for

[16] https://www.independent.co.uk/news/uk/home-news/abortions-marie-stopes-clinic-bonuses-persuade-women-investigation-a8012171.html

	consultation, debate or scrutiny, not to mention sanction, by Parliament. This behaviour was, at the very least, undemocratic and, arguably, unlawful. To render permanent changes that were introduced in so rushed and opaque a way must surely be preceded by, and dependent upon, appropriate scrutiny and debate by Parliament, in England and Wales. Anything less would be shamefully undemocratic. **2. The risk to the safety of more women** In our opinion, face to face consultation is essential, to ensure accuracy of dates, to guard against coercion, to decide if a scan is indicated (either to confirm dates or to rule out an ectopic pregnancy), to provide comprehensive, unbiased information and non-directive counsel, to ensure that appropriate adult help is on hand at home and that emergency help is available in the event it is needed, and to afford an opportunity to the mother to reflect and consider other options. (See answers to Q1 above.) Half-year statistics released by the Department of Health and Social Care[17] show a significant increase in the number of early medical abortions (EMAs) for England and Wales during the first half of 2020, coincident with the introduction of the emergency provisions. The 'pills by post' system has no way to confirm the gestation dates of the women taking the pills, no provision for scanning to confirm dates and exclude ectopic pregnancy, and no physical examination. Therefore, more women are being put at greater risk of complications, including potentially catastrophic haemorrhage. **3. The risk of under-reporting of complications** In response to an FOI request, the Government reported that *'Between April and June 2020, there were 23,061 medical abortions performed on residents of England and Wales where both medicines (antiprogesterone and prostaglandin) were administered at home. Of the 23,061 abortion notification forms received, one form reported a complication.'* Commenting on this report in a post for politics.co.uk,[18] Sally-Ann Hart MP pointed out: *'This would mean that the average rate of complication for medical abortions at a similar gestation over the past five years was over seventeen times higher than the complication rate for home abortions earlier this year.* *'This is not only highly unlikely – that complications would radically reduce in a home setting versus a medical setting – but, some may say, ridiculous.*

[17] https://www.gov.uk/government/publications/abortion-statistics-during-the-coronavirus-pandemic-january-to-june-2020/abortion-statistics-for-england-and-wales-during-the-covid-19-pandemic
[18] https://www.politics.co.uk/comment/2021/01/06/home-abortions-a-disservice-to-women/

	'There is either a serious problem when medical abortions are provided in a clinical environment with direct medical supervision – leading to vastly more complications in clinics than in homes – or a substantial issue with the overall quality of reporting and recording the real impact of 'at-home' medical abortions on women's health.' **4. The risks consequent on there being no audit trail, no scrutiny, and no means to assess outcomes** Abortion providers are not obliged to record NHS numbers and women are not required to report adverse outcomes to their abortion provider. So systematic, objective analysis of the outcomes for women post abortion is undermined in the UK by the absence of full records linking women's health to prior abortion. How is the effectiveness of the present system, were it to be made permanent, to be assessed? How will we learn from mistakes if longitudinal analysis is impossible? That the DHSC can say, as it does on its website, it is 'carefully monitoring the impact,' without putting in place even the most rudimentary scrutiny procedures, beggars belief.[19] As things stand, an abortion at home may not be recorded on a patient's NHS record. Without that information available to them, clinicians may unwittingly interpret subsequent symptoms and/or institute treatment, inappropriately. **5.The risk to the validity of the decision to consent** Even at the best of times, the decision to terminate a pregnancy is a profoundly significant one. From the earliest days of her pregnancy, a woman's intuition is to provide a welcome and a safe place in her womb for her baby. The choice to abort is costly and may lead to later regret. But these are not the best of times. The pressures of isolation, and fears and anxieties around jobs, vulnerable family members, education etc have had a profound effect on the mental health of many. These are not good times for people to be making far-reaching decisions. To have to do so without the opportunity to talk things over in person with trusted medical carers is to make an already difficult situation intolerable. Evidence already cited confirms that women requesting EMA at home are less likely to be given clear and comprehensive information and advice. As a result, consent to the procedure is not fully informed and therefore not valid. We believe that the initial consultation should be with the patient's doctor and that that doctor should routinely have to account for his or her decision to another doctor, who may affirm or resist their colleague's decision.

[19] https://www.gov.uk/government/consultations/home-use-of-both-pills-for-early-medical-abortion/home-use-of-both-pills-for-early-medical-abortion-up-to-10-weeks-gestation

	We believe that this level of care and involvement is essential to the patient's best interests in providing a confidential setting where any coercive factors can be safely discussed, and fears and anxieties gently explored. Only in this way can informed and free consent be assured. We believe this is sufficiently important to justify the very small risk of COVID transmission when undertaken in a COVID secure environment with appropriate PPE and distancing measures. **6. Risk that public concerns are ignored** During the recent consultation on the same subject in Scotland, a poll of Scottish adults[20] was conducted by Savanta ComRes on behalf of The Society for the Protection of Unborn Children (SPUC) to assess public attitudes to home abortions. 84% of respondents to the poll said they were concerned that women might be coerced into an abortion and 86% said they were concerned that women in abusive situations might be pressured into having an unwanted abortion, if they are not able to have a face-to-face consultation. Respondents were made aware of a 'mystery client' investigation in which 26 women were able to receive abortion pills by post after a phone call to an abortion provider in which they gave false information about their identity and gestation (none of the women were pregnant). Having heard this, 91% expressed agreement with the statement, *'It is concerning that callers giving false information can easily obtain abortion drugs'* and 92% with the statement, *'Staff at abortion providers need to ensure that they are collecting correct medical and personal information to certify a woman for a home abortion.'* The Scottish Government's response to the consultation has not yet been made public, and it is not clear whether it will take account of the results of the poll. There is no reason to expect a different outcome were a similar poll to be conducted in Wales. We urge the Welsh Government to give due regard to public concerns, expressed by such means. **We see no means of mitigating these serious risks short of abandoning the emergency provisions as soon as lockdown measures permit and a return to mandatory in-person consultations.**

Q4.	**In your experience, have other NHS Wales services been affected by the temporary approval? If so, which?** The majority of EMAs are arranged through private abortion providers like BPAS and Marie Stopes, though funded by the NHS. However,

[20] https://spuc.org.uk/News/ID/384685/Overwhelming-majority-of-Scots-concerned-about-barbaric-DIY-abortion-in-major-opinion-poll

	when complications arise during home abortions, that require surgical intervention, it is not these providers that step in, but the NHS. According to BPAS's own figures,[21] 3% of women having abortion at home before 9 weeks will require surgical intervention to complete the abortion. This figure rises to 7% for pregnancies between 9 and 10 weeks' gestation. Such complications may present as emergencies, requiring ambulances, blood transfusions, rapid access to surgical theatres and personnel, with implications for other services.

Q5.	**Outside of the Covid-19 pandemic, do you consider there are benefits in relation to safeguarding and women's safety in requiring them to make at least one visit to a service to be assessed by a clinician? Please outline those benefits.** **Yes.** **1. Confirmation of dates** The timing of the two pills, both in relation to the gestation of the pregnancy and to the period between the two pills being taken, is crucial. Usually, the last menstrual period (LMP) is used to estimate gestational age, but LMP alone is not the best obstetric estimate because it assumes a regular menstrual cycle. Studies report that approximately one half of women do not accurately recall their LMP.[22] Examination by a clinician will confirm a correlation between dates and the size of the pregnant uterus or suggest the need for an ultrasound scan to confirm. **2. Exclusion of ectopic pregnancy** In many obstetric centres, ultrasound scanning to exclude ectopic pregnancy, as well as to confirm dates, is a routine procedure. Exposing an undisclosed ectopic pregnancy to the effects of the abortion pills may produce torrential bleeding resulting in a surgical emergency. At home, with inexperienced support, this would be as terrifying as it would be life-threatening. **3. Uncovering abuse, coercion or impersonation** Telemedicine cannot reveal the presence of coercion. Only in a secure, supportive and confidential setting, away from the abusive relationship, may a woman find the courage to open up and to make a free choice about her pregnancy. 'Pills by post' cannot guarantee that the person requesting the pills will be the person taking them.

[21] https://www.bpas.org/abortion-care/abortion-treatments/the-abortion-pill/abortion-pill-up-to-10-weeks/

[22] https://www.healthcare.uiowa.edu/familymedicine/fpinfo/OB/OB2017/ACOG%20redating%20gestational%20age.pdf page 2.

	There is also the concern that pills may be being procured for underage girls and/or victims of sexual abuse. Retaining face-to-face visits would retain the chance for these girls to raise the alarm and receive help. **4. 'Cooling off period' for non-directive information and reflection** Decisions made in haste may be regretted for a lifetime. Consent is not fully informed if it is given under duress, or on the basis of only partial understanding of the options available. A supportive environment and access to non-directive counselling, before and, if abortion happens, after abortion, are essential to the consent process, we believe. **5. Ensuring that mature adult help and available back up emergency services are in place** No woman should have to flush away the recognisably human form of her aborted baby. **6. Arrangement for a follow up pregnancy test to confirm full expulsion of uterine contents, and to discuss contraception options**

Q6.	**To what extent do you consider making permanent home use of both pills could have a differential impact on groups of people or communities? For example, what is the impact on people with a disability or on people from different ethnic or religious backgrounds?** Nobody should be required to participate in enabling abortion at home, for example by posting pills, if to do so would conflict with their sincerely held beliefs, religious or otherwise. We urge the Welsh government to extend respect for conscience to cover all related procedures.

Q7.	**To what extent do you consider that making permanent home use of both pills for EMA would increase or reduce the difference in access to abortion for people from more economically disadvantaged areas or between geographical areas with different levels of disadvantage?** Wales does not have the large number of small, remote island communities that Scotland does, but it does have many remote, rural, valley settings where public transport may be intermittent and house calls by GPs may be limited. We appreciate that not having to wait for a GP to visit such a community could be viewed as a significant advantage. However, we would argue that it is better to be

	inconvenienced early on than be put at risk later in the process when emergency help might not be at hand. On balance we believe that women living in rural communities would be better served, and safer, under a provision that mandated face-to-face consultations, and would suggest that financial assistance be made available to women in poverty to enable them to travel to those consultations.

Q8.	**Should the temporary measure enabling home use of both pills for EMA:** **1. Become a permanent measure? NO** **2. Remain unaffected (i.e. be time limited for two years and end two years after the Coronavirus Act came into force (25 March 2022), or end on the day on which the temporary provision of the Coronavirus Act 2020 expire, whichever is earlier). NO** **3. Other [please provide details]? YES** It is our view that the emergency provisions, intended to cover lockdown, should be discontinued immediately. Clinics have re-opened, and access is restored. We believe that initial face to face clinical assessment by a healthcare professional, provision of non-directive information and support, pre-decision counselling and time for reflection, and follow-up support including a check pregnancy test, should all be routine and be reinstated immediately. Both pills should be taken in a clinic. Following misoprostol, the woman should remain in the care of the clinic until the abortion is deemed by clinicians to be complete. Resuscitation equipment, and staff trained to use it, must be on hand throughout. We believe the small risk of COVID-19 transmission this would involve is outweighed by the safety risks of continuing with the emergency regulations. For reasons given above, non-directive information, counsel and support should not be left to abortion-providers alone to supply. (It is possible to conceive of a situation where there may be insuperable barriers to accessing normal face to face abortion care, [for example, where there really is domestic abuse that is preventing a woman from leaving the house], such that her choice is between no care and telemedicine, then we would see remote care as the 'lesser of two evils.' This should not be interpreted as approval of the current blanket proposal, that we strenuously oppose, but as hesitant openness to the use of telemedicine under such exceptional and rare circumstances.)

Responses to consultations are likely to be made public, on the internet or in a report. If you would prefer your response to remain anonymous, please tick here: