Consultation Response Form

Your name: ***[information redacted]***

Organisation (if applicable):ABUHB

email / telephone number: ***[information redacted]***

Your address:

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.** There has been an improvement in accessibility and provision. As an initial consultation is performed on the phone, the average wait for an appointment from first call is 1-2 days rather than 1-2 weeks. 95% women are now accessing medical rather than surgical abortion (previously this was 75%) which is much less costly for the health economy. The average gestation of treatment has fallen (now 6+5 rather than 7+2 in 2019) and the risk of complications especially retained products of conception and failed treatment has fallen.In the previous system patients would spend 1-2 hours in the clinic and now this is usually < 15 minutes. We performed a telephone survey of patients using the service over 3 months. 89% said they were 'extremely happy' with their care and 96% said that if they needed to have another abortion they would rather chose telemedicine. **Comments included** 'This is much more private and personal' ' I preferred talking about this on the phone because it is so sensitive' ' This is embarrassing – it's so much easier on the phone' 'Very well organised service' 'My previous experience was very distressing – this is so much better'

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.** Staff feel very positive about the service they are offering and feel it is much more satisfying and cohesive. There is better continuity of care for patients and the fact that all legalities and medication are arranged before attendance mean the process is much smoother for patients.

	It has been extremely useful because staff who have been shielding during COVID have been able to contribute to service delivery whilst home working. The service model is much more efficient and in the past we had to refer many of our patient to a private provider. As a result of the new model of service delivery we have been able to see 30% more patients within the ABUHB service that we were previously able to.

Q3.	**What risks do you consider are associated with the temporary measure? If you consider that there are risks, can these risks be mitigated?** The service provision is more robust. Previously a patient had to see many different health professionals during one episode of care. There is now better continuity of care for patients with all risks and potential medical complications assess before rather than during the patient attendance. We have not seen any adverse incidents related to no scan being performed. Since the introduction there have been 3 ectopic pregnancies, all appropriately managed**.**

Q4.	**In your experience, have other NHS Wales services been affected by the temporary approval? If so, which?** There has been less need to utilise early pregnancy and gynaecology services as there have been fewer complications with women being treated at earlier gestation. Services have also been helped by the introduction of 'Frisky Wales' on line sexual health services which mena that women can undertake a postal sexual health screen prior to their attendance at the service or for their treatment.

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.** A safeguarding assessment is a routine part of all ABUHB abortion care telephone consultations. In addition our patients are provided with a 'safe word' that can be used to signal danger when a health professional calls them. Our staff are vigilant and ask women not to use speaker phones and can initiate a video consultation if there is ant fear of coercion. We do not feel that the majority of women require face to face assessment for safeguarding. However, we do a more robust safeguarding assessment for all under 18s and we have continued to see all under 18th and anyone who triggers our safeguarding risk assessment for a face to face consultation. All patients are given the opportunity to speak to a counsellor if they would like to.

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?** Permanent provision of telemedicine would directly benefit those that are otherwise disadvantaged, particularly with regard to needing postal medication. Women with disabilities may struggle to travel to clinics. Women who need to conceal a pregnancy because of risk of violence can access care more safely and women who are part of communities where culture or religion disagrees with abortion have a better access to services.

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?** Easier access to medication (including postal delivery) would improve provision to women who are most disadvantaged economically, socially isolated or affected by geographical isolation or poor transport links.

Q8.	**Should the temporary measure enabling home use of both pills for EMA:** **1. Become a permanent measure?** **Yes** **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).** **3. Other [please provide details]?**

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:

Termination of pregnancy arrangements in Wales

Consultation Response Form

Our names: ***[information redacted]***

Organisation: Cardiff & Vale University Health Board

email / telephone number:
[information redacted]

Our address: ***[information redacted]***

BACKGROUND

Novel coronavirus (SARS-COV-2) is a new strain of coronavirus causing Covid-19, first identified in late 2019. Since March 2020, Covid-19 has been present in the UK, resulting in a series of social restrictions to limit and control transmission including national and local 'lockdowns', restrictions on travel, and limitations on household mixing.
In March 2020 the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of Midwives, the Faculty of Sexual and Reproductive Healthcare, and the British Society of Abortion Care Providers produced clinical guidance for the provision of abortion care during the COVID-19 pandemic.
This guidance recommends provision of Early Medical Abortion via telemedicine to minimise risk and maintain provision of abortion as a time-sensitive, essential service. Specifically, it recommends:

- Providing remote consultation via video or telephone call and limiting in-clinic care.

- use ultrasound assessment only when clinically indicated – such as in case of symptoms or history of ectopic pregnancy, the presence of an Intra-uterine device, or uncertainty about the date of last menstrual period.

Under the Abortion Act 1967, abortion treatment may only be provided in NHS hospitals and on premises licensed for the purposes by the Secretary of State for Health and Social Care.
At the beginning of the outbreak, women with pregnancies up to 10 weeks' gestation were able to take the second part of an Early Medical Abortion (misoprostol) at home but had to attend a hospital or clinic to take the first medication (mifepristone).
On 30th March 2020 in England, and 31st March in Scotland and Wales, women's homes were licensed to allow home use of mifepristone. In Wales, this applies to care up to 9 weeks and 6 days' gestation.

SERVICE MODEL IN CARDIFF & VALE UHB SINCE SPRING 2020

- _A video- or telephone consultation with a doctor or nurse which includes a pregnancy options discussion, assessment of safety at home, medical history, assessment of gestational age by last menstrual period, determination of the need for an ultrasound, and a discussion about STI testing and ongoing contraception. All information discussed was followed by electronic sharing of information (e-mail / WhatsApp or text messaging) with patient.

- Additional safeguarding for under-18s include questions designed to assess the likelihood of Child Sexual Exploitation, and identification of a responsible adult present while undergoing the termination. Where an under-18 has a social worker or contact with mental health services, their caseworker will be informed. If there are doubts the teenager is invited to attend clinic for a face-to-face discussion and consideration of in-patient treatment.

- If required, an appointment for ultrasound scan, addressing of safeguarding issues or pre-treatment blood tests.

- The review of notes and assessment by two doctors who will either ask for further information or provide the legally required signatures and prescribe the medication.

- Courier-delivery of treatment pack containing written information about early medical abortion treatment, the medication mifepristone and misoprostol, a low-sensitivity pregnancy test to take two weeks after treatment to confirm success. When requested, a supply of contraceptive pills is also included in the pack. The package is marked 'NHS' and delivered in person by the UHB's pharmacy delivery service. Women may also collect this package from the clinic in central Cardiff if they prefer.

- Online and video instructions, and access to BPAS's 24-hour aftercare line staffed by BPAS nurses and midwives who answer medical queries and provide help and assistance to clients. Under-18s and vulnerable adults will receive a telephone call three weeks after treatment to ensure that the abortion was completed successfully, and no further care is required.

- If a young or vulnerable woman does not attend a scheduled appointment or cannot be reached for follow-up, this will be managed via existing safeguarding pathways.

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.** **Yes – the approval had a very positive impact for women in Cardiff & Vale** The local audit process as well as many discussions with local clinicians and patients confirmed the findings of larger, published reviews of the home-use of Mifepristone during 2020 (ref 1, 2, 3). 1) Aiken A, Lohr PA, Lord J, et al. Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study. BJOG 2021 doi: 10.1111/1471- 0528.16668 2) Finch RE, McGeechan K, Johnstone A, et al. Impact of self-administration of misoprostol for early medical abortion: a prospective observational cohort study. BMJ Sexual & Reproductive Health 2019;45:296-301. 3) Reynolds-Wright JJ, Johnstone A, McCabe K, et al. Telemedicine medical abortion at home under 12 weeks' gestation - a prospective observational cohort study during the COVID-19 pandemic. BMJ Sex Reprod Health 2021 doi: 10.1136/ bmjsrh-2020-200976

SAFETY

Although no medical intervention is without risk, abortion treatment provided by trained clinicians is a safe procedure and safer than continuing a pregnancy to term. Early Medical Abortion has been established as a safe treatment option routinely used in Wales and throughout the UK for hundreds of thousands of women.
Before this latest change facilitating telemedical abortion, more than 100,000 women a year self-managed their abortion at home. This home-treatment is known to be safe and has remained in place. New are the remote rather than in-clinic assessment and removal of legal requirement to take the first part of treatment (one tablet of Mifepristone by mouth) in the clinic.
Our local impression and review of complex cases was reassuring, found no new safety issues and echoes findings of a large cohort study based on Independent Service Provider data from England and Wales (see Ref 1). This study reports the evaluation of 52,142 medical abortions – 22,158 carried out before the change in regulation and 29,984 afterwards. This latter group was the telemedicine-hybrid cohort.
The study found no differences in treatment success between the two groups (98.2% vs 98.8%) and no differences in the prevalence of serious adverse events (0.04% vs 0.02%). The incidence of ectopic pregnancy was equivalent in both cohorts (0.2%), with no difference in the proportions being treated after abortion (0.01% vs 0.03%). In the telemedicine-hybrid group, the effectiveness for abortions conducted using telemedicine was 99.2% compared with 98.1% in the traditional group.
In very rare instances (0.04% in this review) home treatment took place at gestation above 10 weeks. These cases did not result in additional complications.

Safety was improved further due to reducing risk of covid-19 which is known to be potentially more sinister in pregnancy. The change in regulation meant that women who need abortion treatment but have no clinical need to attend the service in person could avoid the risks of contracting or transmitting Covid-19. This is even more important for those women who are clinically vulnerable.

ACCESSIBILTY AND CONVENIENCE OF SERVICES

We know that being required to travel to a clinic is difficult for many women. There may be limited access to transport, they need to take extra time off work and finding childcare can be difficult and expensive. An appointment can be lengthy because of the legal requirement for two doctors to authorise the abortion treatment. Finally the discreetness of a consultation in her own home was frequently mentioned as positive by patients grateful not to have to attend clinic for management of an unwanted pregnancy.
Telemedicine helps us safely treat women in a way that fits in with their lives – while ensuring they are treated by trained professionals and provided with the support they need.

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.** The change has had a positive impact. UK Abortion providers have described the changes in regulation as 'revolutionary' and 'one of the success stories of the pandemic'. The change has enabled services in Wales to provide safe and effective services that are more accessible than ever before. For all NHS services and most definitely here in Cardiff, telemedicine has enabled continuing service provision during the pandemic even when staff have been quarantined or redeployed. Remote working and patients who are grateful not to have to wait or attend clinic helped staff morale during an otherwise extremely difficult time in the NHS workforce.

Q3.	**What risks do you consider are associated with the temporary measure? If you consider that there are risks, can these risks be mitigated?** *MEDICAL PROCEDURES AND RISK* Abortion is a low-risk medical procedure, safer than continuing a pregnancy to term. Clinical risk is an aspect of all forms of medical care – which is managed by the patient's clinical team in discussion with the patient. In line with the position of leading medical bodies such as the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives, abortion is best managed as medical care between a woman and her clinical team. Abortion providers across Great Britain have worked hard to establish a safe, effective, and accessible telemedical abortion model at a time when all other healthcare has been under substantial pressure. This has resulted in thousands of women in Wales accessing care that otherwise they may have struggled to obtain. Women need to be able to get in touch and 24 hour phone numbers as well as e-mail contacts are provided in Cardiff. In a large survey by a UK charity 3.1% of patients contacted a hospital following their procedure – no different from the small number who contacted NHS services after early medical abortion care without a telemedicine. The safety and acceptability of telemedicine in abortion care is already supported by a large number of medical Royal Colleges and clinical groups, including the RCOG, BMA and FSRH. *ECTOPIC PREGNANCY*

	The overall rate of ectopic pregnancy and complications related to ectopic pregnancy are low in the UK. According to NICE, the rate of ectopic pregnancy is 11 per 1,000 pregnancies. In line with other research, a large scale cohort study of women wit unwanted pregnancies in the UK found a smaller prevalence amongst them: 2 in 1,000 clients presenting with an extrauterine pregnancy (see Ref 1). Women seeking abortions are screened for ectopic pregnancy and have historically been exposed to ultrasound scanning at an earlier stage than those who intend on continuing their pregnancies, even though the risk of ectopic pregnancy is higher in the latter group. In maternity care, ultrasound is not used for routine screening of asymptomatic women, and the first routine ultrasound scan does not take place until 12 weeks. An important part of telemedical consultation and scan screening for abortion services is assessing a woman for likelihood of ectopic pregnancy – to this end we developed a clinical flow-chart to standardise screening of ectopic risk. Any woman who is symptomatic or who has a risk factor for an ectopic pregnancy will be invited for ultrasound scan and assessment in clinic. NICE guidelines are clear that Early Medical Abortion can be provided before there is definitive evidence of an intrauterine pregnancy, and the nature of scanning at very early gestations makes detection of extrauterine pregnancies more difficult and result in high rates of false positives. There is no clinical risk to patients with an ectopic pregnancy of taking abortion medication – patients are asked to confirm their understanding that a small risk of an abnormal pregnancy (ectopic or molar) remains and will require additional treatment. This approach has been confirmed as safe by the already cited large cohort study (Ref 1) which reported that the telemedical model 'resulted in very low rates of undiagnosed ectopic pregnancy' (0.03%). Ectopic pregnancies diagnosed after abortion treatment present a minimal risk which is present regardless of the care pathway. In summary the small possibility of an undiagnosed ectopic does not present an additional risk for telemedicine abortion because 1) the incidence of ectopic pregnancy is very low in abortion patients 2) the outcome is not influenced by the care pathway, 3) screening for ectopic pregnancy takes place at an earlier gestation in abortion care than for women continuing pregnancies, thus making early detection more likely 4) the majority of ectopic pregnancies are detected prior to treatment in both the in-person and telemedical care pathways 5) ectopic pregnancies are not complicated by Early Medical Abortion treatment. *LATE FOR LMP PRESENTATIONS* Since the change in clinical practice to rely on Last Menstrual Period (LMP) rather than a scan for determining gestational age, there have been a very small number of cases involving gestations outside the 10-week limit for pills at home. This risk appears to be very low at 0.04% (see Ref 1). It would thus require the NHS to perform scans of 10,000 women in order to prevent home treatment of four women whose pregnancy was further than 10 weeks. Practices of ultrasound use in early pregnancy is neither part if this consultation nor subject to Government approval but is based on clinical guidelines and best practice.

	There is no clinical justification for supporting an invasive intervention on this basis and for this reason, routine scanning will not be resumed. This means that whatever decision is reached about the future of home use of the first part of Early Medical Abortion, the extremely low risk of a woman receiving treatment outside of the 10-week gestational window will remain.

Q4.	**In your experience, have other NHS Wales services been affected by the temporary approval? If so, which?** Before the approval of mifepristone at home, women in Wales chose and received early medical abortion treatment meaning they passed their pregnancies at home. Even before home use of misoprostol was approved in 2018, women did not remain in hospital to pass their pregnancy, but often while suffering the early stages of miscarriage on their way home. Complications in need of healthcare support are likely to happen at this stage and will therefore be no different when using Mifepristone at home. The large cohort study (see Ref 1) found that there were no differences to complications after the change to telemedical abortion care, and indeed that some complications which may require further treatment such as continuing pregnancies had declined. As a result, there is absolutely no reason to suggest that there has been a wider impact on NHS Wales services as a result of the change. More broadly, since the introduction of telemedicine the waiting times for assessment is much reduced and the average gestational age at the time of treatment lower. This may have an effect on fewer attendances in GP surgeries, early pregnancy assessment clinics and gynaecology services as common early pregnancy complications are picked up and managed by the abortion service as the first point of contact.

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.** No – in fact, based on evidence from the past year, forcing clinic attendance is likely to result in reduced safeguarding disclosures and increasing numbers of vulnerable women and girls turning to illegal, unregulated sources of abortion medication online. Telemedicine, with in-person care where necessary, provides the best options for women who are victim-survivors of sexual violence or domestic abuse, particularly those for whom leaving home for the length of time needed to attend appointment would be unsafe. Abortion providers ask each woman whether they feel safe at home – both those treated in-person and via telemedicine. The UHB's safeguarding team will be involved and cases managed in line with relevant guidance. NHS bodies have established an excellent working relationship social services and the police, as well as local charities and organisations to help women who need us. Since telemedicine started, we have

	found that clients are more comfortable disclosing domestic abuse and other Problems when talking from within their more familiar setting – enabling us to better support them, whatever their need. Telemedicine is not a barrier to discussing safeguarding or domestic abuse concerns. We also know that women who have previously struggled to access in-clinic care, including women in abusive relationships, are no longer sourcing help outside the regulated healthcare system. Organisations such as "Women on the Web" have previously been contacted by Welsh women unable to access care as a result of their home circumstances and thus sought (illegal) abortion care at home. Such requests are no longer made since women are instead seeking care via legal means.

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?** Everyone should be able to access safe, free abortion but with a legal requirement to attend a clinic. This access is disproportionately more difficult for certain vulnerable groups: Disabled women, LGBT people and care-experienced women and girls in Wales will often experience difficulties in accessing reproductive health services. For these groups, the costs of travel and childcare present additional barriers to abortion thus creating a greater impact on women facing multiple deprivations and discrimination. Telemedicine enables providers to tailor care to individual women and their needs.

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?** In the 21st Century, socio-economic status should not impact one's ability to access reproductive healthcare, but sadly it does. There are hidden costs to accessing abortion services, some of which are removed by telemedicine and early medical abortion at home. Women face structural issues of socio-economic disadvantage which may leave them struggling to access care. The following example illustrate this point: • The high cost of childcare

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

Q8.	**Should the temporary measure enabling home use of both pills for EMA:** **1. Become a permanent measure?** Yes. We support the permanent approval of home use of mifepristone.

Q9. & Q10.	**We would like to know your views on the effects that the Termination of pregnancy arrangements in Wales would have on the Welsh language, specifically on opportunities for people to use Welsh and on treating the Welsh language no less favourably than English.** **What effects do you think there would be? How could positive effects be increased, or negative effects be mitigated?** Welsh language availability is key to provision within the NHS Wales. We do not believe there is any impact on the Welsh language of telemedical abortion care. Cardiff & Vale UHB provides abortion information and clinical care in Welsh where requested. However, not all of our staff members speak Welsh. The provision of telemedical care enables us and other providers to book appointments specifically with Welsh-speaking staff if requested, whereas in-person care relies on staff availability and potentially increased waits for Welsh-speaking staff to become available. Telemedical abortion care is provided by the same staff as in-person care throughout Wales, so in and of itself, there will be no impact of this change on the availability of care in Welsh. **Please also explain how you believe the proposed arrangements could be formulated or changed so as to have positive effects or increased positive effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language, and no adverse effects on opportunities for people to use the**

	Welsh language and on treating the Welsh language no less favourably than the English language. Abortion care is an NHS service, and as such should be treated no differently to other healthcare when considering the effects of the Welsh language.

Q11.	**We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them** The Welsh approval for mifepristone at home differs from the Scottish approval in two key ways: • The gestational limit is included in law; and • There is a link to provision from a hospital or licensed premises. Both of these can place additional pressures on providers and women in receiving the best possible care. The ability to provide the best possible abortion care in Wales should be governed by clinical frameworks and guidelines, and not by the criminal law. In Scotland, the Scottish Abortion Care Providers network determined that 12 weeks' gestation was the more appropriate limit for home use of mifepristone and misoprostol – a finding supported by international evidence. Their framing also better allows effective cross-border care, and care grounded in the qualifications of clinicians providing care (doctors, nurses, and midwives in the case of Wales) rather than it being tied to other licensed premises. The ability to provide mifepristone at home would also help women in Wales having later abortions, including on the grounds of severe or fatal fetal abnormality, who would no longer need to attend multiple, unnecessary appointments. Instead, they could take mifepristone at home before attending to pass their more advanced pregnancy in hospital. We would recommend that the Welsh approval of mifepristone at home is made permanent, but that it is reframed to reflect the Scottish approval – without a gestational limit in law, and focused on the qualifications of the doctors, nurses, and midwives providing abortion care.

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:

Consultation Response Form

Your name: ***[information redacted]***

Organisation (if applicable): National Secular Society

email / telephone number:
[information redacted]

Your address: ***[information redacted]***

1. About the National Secular Society

1.1. This submission is made by the National Secular Society (NSS). The NSS is a not-for-profit non-governmental organisation founded in 1866, funded by its members and by donations. We advocate for separation of religion and state and promote secularism as the best means of creating a society in which people of all religions and none can live together fairly and cohesively. We seek a diverse society where all are free to practise their faith, change it, or to have no faith at all. We uphold the universality of individual human rights, which should never be overridden on the grounds of religion, tradition or culture.

1.2. We campaign to protect patients from harm caused by the imposition of other people's religious values. We advocate for a secular approach to current major health issues. We are opposed to religious influences in medicine where these adversely affect the manner in which medical practice is performed. We support patient autonomy and challenge pro-religious discrimination, particularly in those areas of medicine where reasonable personal choice is threatened.

1.3. We strongly support the right of women to have legal and safe abortions and access to emergency contraception.

1.4. Our response has been prepared with the input of our Secular Medical Forum and practitioners with experience in the area of early medical abortions.

2. Comments on the consultation

2.1. We welcome this opportunity to respond to the Welsh Government's consultation on early medical abortion at home.

2.2. The primary consideration should be the safety and welfare of women seeking abortion services. The Welsh Government should ensure all people from all backgrounds and communities can access safe, timely, non-judgmental healthcare including abortion care and sexual health counselling and treatment.

2.3. The Royal College of Obstetricians and Gynaecologists and the Faculty of Sexual and Reproductive Healthcare have found that the risks of early medical abortions at homes compared to attending a hospital or approved setting are negligible. The risks are likely outweighed by the benefits of earlier, and therefore safer, abortions, in addition to more accessibility and patient choice as to the location of treatment.

2.4. As Dr Edward Morris, President of the Royal College of Obstetricians and Gynaecologists, says:

> "The statistics…show that while many healthcare services have paused during the pandemic, access to abortion has been not only maintained but improved through the innovative use of telemedicine. This has reduced unnecessary visits to clinics and increased the safety of abortion care. It has also protected both women and their families, as well as healthcare professionals, from possible coronavirus infection and transmission. The data demonstrates why the temporary use of telemedicine for early medical abortion must be made permanent."[1]

2.5. The risk of having to attend an approved setting for an abortion is especially high for women and girls from religious communities which are disapproving of abortion. Frequently, their doctor and their pharmacist may also be from the same community which presents a potential barrier to care because some women would be fearful of approaching such a healthcare professional for fear of breach of confidentiality. Younger women, girls and those without independent means may not have the resources or information to travel further afield to seek appropriate care.

2.6. The main potential benefit of remote consultations to facilitate treatment for some vulnerable people is that they can consult from their own home without having to explain where they are going or having to consult a doctor or pharmacist from their local community.

2.7. An additional benefit of remote access for all women seeking abortions is that it mitigates the risk of having to run the humiliating and daunting gauntlet of anti-choice protestors outside abortion facilities and helps to support confidentiality.

2.8. In some cases, face to face consultations are a preferred choice for those seeking abortions, and so these should still be available for people who wish to attend in person or if the healthcare professional conducting the remote consultation feels that it would be safer to do so.

2.9. We note that most objections to early medical abortions at home and remote consultations come from those who ideologically oppose abortion under all circumstances, and seek to make it harder for women to access abortion

[1] Quoted in 'FSRH statement: Royal College of Obstetricians and Gynaecologists and Faculty of Sexual and Reproductive Healthcare respond to latest abortion statistics in England and Wales'. Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists, 10 September 2020. https://www.fsrh.org/news/fsrh-rcog-statement-abortion-rates-2020-covid19/ Accessed 15 December 2020.

services. Many of these objections are rooted in religious teachings about sex. Religious ideology should not be permitted to determine healthcare policies, especially when accommodating religious beliefs will undermine the health, safety and well-being of patients of all religion and belief backgrounds.

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.** Yes. The Royal College of Obstetricians and Gynaecologists and the Faculty of Sexual and Reproductive Healthcare have found that the risks of early medical abortions at homes compared to attending a hospital or approved setting are negligible. The risks are likely outweighed by the benefits of earlier, and therefore safer, abortions, in addition to more accessibility and patient choice as to the location of treatment. As Dr Edward Morris, President of the Royal College of Obstetricians and Gynaecologists, says: “The statistics…show that while many healthcare services have paused during the pandemic, access to abortion has been not only maintained but improved through the innovative use of telemedicine. This has reduced unnecessary visits to clinics and increased the safety of abortion care. It has also protected both women and their families, as well as healthcare professionals, from possible coronavirus infection and transmission. The data demonstrates why the temporary use of telemedicine for early medical abortion must be made permanent.” An additional benefit of remote access for all women seeking abortions is that it mitigates the risk of having to run the humiliating and daunting gauntlet of anti-choice protestors outside abortion facilities and helps to support confidentiality.

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.** Yes. The temporary measure has allowed healthcare staff to conduct timely, safe, remote consultations. This has mitigated the risk of Covid-19 transmission for both patients and healthcare professionals and has reduced unnecessary travel. The temporary measure has also facilitated

	an efficient use of limited healthcare personnel, some of whom may have been physically deployed to another area due to the Covid-19 pandemic and who would not otherwise have been able to continue to provide this service.

Q3.	**What risks do you consider are associated with the temporary measure? If you consider that there are risks, can these risks be mitigated?** The Royal College of Obstetricians and Gynaecologists and the Faculty of Sexual and Reproductive Healthcare have found that the risks of early medical abortions at homes compared to attending a hospital or approved setting are negligible. The risks are likely outweighed by the benefits of earlier, and therefore safer, abortions, in addition to more accessibility and patient choice as to the location of treatment. As Dr Edward Morris, President of the Royal College of Obstetricians and Gynaecologists, says: “The statistics…show that while many healthcare services have paused during the pandemic, access to abortion has been not only maintained but improved through the innovative use of telemedicine. This has reduced unnecessary visits to clinics and increased the safety of abortion care. It has also protected both women and their families, as well as healthcare professionals, from possible coronavirus infection and transmission. The data demonstrates why the temporary use of telemedicine for early medical abortion must be made permanent.” The risk of having to attend an approved setting for an abortion is especially high for women and girls from religious communities which are disapproving of abortion. Frequently, their doctor and their pharmacist may also be from the same community which presents a potential barrier to care because some women would be fearful of approaching such a healthcare professional for fear of breach of confidentiality. Younger women, girls and those without independent means may not have the resources or information to travel further afield to seek appropriate care. The main potential benefit of remote consultations to facilitate treatment for some vulnerable people is that they can consult from their own home without having to explain where they are going or having to consult a doctor or pharmacist from their local community. An additional benefit of remote access for all women seeking abortions is that it mitigates the risk of having to run the humiliating and daunting gauntlet of anti-choice protestors outside abortion facilities and helps to support confidentiality.

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.** No. For the reasons given above, for many women it is safer not to visit a service. It should therefore not be a requirement. In some cases, face to face consultations are a preferred choice for those seeking abortions, and so these should still be available for people who wish to attend in person or if the healthcare professional conducting the remote consultation feels that it would be safer to do so. We note that most objections to early medical abortions at home and remote consultations come from those who ideologically oppose abortion under all circumstances, and seek to make it harder for women to access abortion services. Many of these objections are rooted in religious teachings about sex. Religious ideology should not be permitted to determine healthcare policies, especially when accommodating religious beliefs will undermine the health, safety and well-being of patients of all religion and belief backgrounds.

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?** The risk of having to attend an approved setting for an abortion is especially high for women and girls from religious communities which are disapproving of abortion. Frequently, their doctor and their pharmacist may also be from the same community which presents a potential barrier to care because some women would be fearful of approaching such a healthcare professional for fear of breach of confidentiality. Younger women, girls and those without independent means may not have the resources or information to travel further afield to seek appropriate care. The main potential benefit of remote consultations to facilitate treatment for some vulnerable people is that they can consult from their own home without having to explain where they are going or having to consult a doctor or pharmacist from their local community.

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?** We think it would reduce the difference in access to abortion from people

	from marginalised groups. The risk of having to attend an approved setting for an abortion is especially high for women and girls from religious communities which are disapproving of abortion. Frequently, their doctor and their pharmacist may also be from the same community which presents a potential barrier to care because some women would be fearful of approaching such a healthcare professional for fear of breach of confidentiality. Younger women, girls and those without independent means may not have the resources or information to travel further afield to seek appropriate care. The main potential benefit of remote consultations to facilitate treatment for some vulnerable people is that they can consult from their own home without having to explain where they are going or having to consult a doctor or pharmacist from their local community.

Q8.	**Should the temporary measure enabling home use of both pills for EMA:** **1. Become a permanent measure?** Yes.

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:

Consultation Response Form

Your name: Decolonising Contraception CIC

Organisation (if applicable): Decolonising Contraception CIC

email / telephone number:
[information redacted]

Your address: ***[information redacted]***

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.** ● Decolonising Contraception C.I.C. believe that abortion is an essential and routine part of reproductive healthcare that should be guided by clinical best practice, not government regulation. ● We believe that home use of both medications (mifepristone and misoprostol) for early medical abortions (EMA) up to 10 weeks, thus allowing for fully telemedical 'no-test' provision, has been a safe, effective and positive change that is acceptable to patients and providers. Telemedical EMA has improved accessibility and convenience, particularly for the most vulnerable members of our society. ● Abortion is a very safe procedure at all gestations, and is in all instances, when performed in line with best clinical practice, safer than continuing a pregnancy to term (RCOG, "Best practice in comprehensive abortion care", June 2015). ● Abortion is safer the earlier it is performed – and telemedicine has resulted in a drop in average gestation and abortions being performed earlier than ever before. According to DHSC Abortion statistics for England and Wales during the COVID-19 pandemic, 30% of abortions are now performed before 6 weeks'

gestation (since the introduction of telemedical abortion services), compared to only 13.5% in the same period in 2019, indicating improved access and reduction in waiting times.

- Before this change, people seeking abortions had to attend a licensed clinic or hospital, which may be a long distance from their home (particularly in more rural areas of Wales such as the north or south west). This would require people seeking abortions to have access to transport (public or private), to take time off work, pay for childcare, and often bring a partner or friend with them. This meant that abortion care often had quite a high cost to those seeking abortions. Telemedicine has removed these barriers.
- Telemedicine EMA is highly acceptable for patients seeking an abortion, especially those for whom in-clinic visits are logistically or emotionally challenging. In a MSI Reproductive Choices (MSUK) study (Erlank et al. 2021) of 1243 patients undergoing telemedicine EMA in England between April-August 2020, the majority (83%) reported preferring telemedicine and 66% indicated that they would choose telemedicine again if COVID-19 were no longer an issue.
- A newly published study of 52,142 women attending the three largest abortion providers in England - British Pregnancy Advisory Service (BPAS), MSUK and the National Unplanned Pregnancy Advisory Service (NUPAS) examined telemedical EMAs from April-June 2020 (as a hybrid model with in-person consultations for those deemed ineligible for no-test EMA). This cohort accounted for 85% of all medical abortions that took place in England and Wales during the study period. Aiken et al. (2021) demonstrated that telemedicine:
    - improved access, with a significant reduction in mean waiting time from 10.7 days to 6.5 days, and a significant reduction in mean gestational age (with 40% vs 25% of abortions at 6 weeks' gestation or less);
    - is no less effective in terms of rates of success rate;
    - safe, with no evidence of a higher incidence of significant adverse events;
    - and acceptable, with 80% reporting they would choose telemedicine again in the future.
- A prospective observational cohort study (Reynolds-Wright et al, 2021) of 663 women choosing telemedical EMA in Scotland between April-July 2020 also demonstrated the safety, efficacy (98% success), and acceptability (95% rated their care as somewhat or very acceptable) of telemedical abortion care.

	Whilst this study examined telemedical EMA up to 12 weeks' gestation, 98.2% of the cohort were under 10 weeks' gestation.

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.** ● Telemedical care has enabled providers to deliver a safe, effective, and accessible abortion service. ● Telemedicine is recognised by NICE as a way of improving access, one of the key priorities of the NICE guideline on abortion care (NG140, updated September 2019). Their systematic review (O'Shea et al, 2020) found that, amongst other things, remote services, community services, and reduced waiting times should improve the sustainability of and access to abortion services, most likely for those in vulnerable groups. ● Welsh abortion providers report that the change in regulation enables them to provide high quality care that is appropriate to the woman they are treating – rather than requiring everyone to attend a clinic either repeatedly or for prolonged periods while the requirements of the Abortion Act are met ● As per Aiken et al. (2021, referenced in Q1), the introduction of telemedical no-test abortion has led to a reduction in gestation at time of treatment, coupled with no changes to complication rates. Analysis indicates that this will, in the medium to long term, reduce the costs of providing an early medical abortion service – enabling Health Boards to focus on using money to

	improve service provision eg for later or more complex care, contraception, or STI testing ● Some NHS providers have previously required those seeking abortions to attend multi-day appointments, or receive a referral which is contrary to NICE guidance so that their HSA1 abortion form can receive one signature – as the abortion service is run by a single doctor. They report that the change in regulation has allowed them to do this work behind the scenes – so those seeking abortions are not delayed or forced to attend unnecessary appointments in order to access care. ● The current approval in Wales has enabled greater flexibility in terms of service provision models (including telephone appointments and a collection service, delivery of care via remote clinics, and postage to users' houses) and workforce - allowing doctors who are shielding, or self-isolating, or with childcare commitments to work from home. Overall, such flexibility leads to a more efficient and cost effective service ● Abortion providers across Wales report that this change has been 'revolutionary' to their services – enabling them to drastically reduce waiting times, minimise the need for repeat visits or referrals via other care, and reduce the gestational age at which abortions are provided ● Although clinical guidance was updated at the same time to recommend a 'scan as indicated' model for those seeking abortions early in pregnancy, this is not something governed by this consultation. Government should not play a role in clinical best practice, and specifically not implement rules which result in requiring people early in pregnancy to undergo transvaginal scanning.

Q3.	**What risks do you consider are associated with the temporary measure? If you consider that there are risks, can these risks be mitigated?** ● Although no healthcare is risk-free, abortion is a low risk procedure which in all instances is safer than continuing a pregnancy to term ● Abortion providers across Wales and Great Britain have worked hard to establish a safe, effective, and accessible telemedical abortion model at a time when all other healthcare has been under substantial pressure. This has meant thousands of people seeking abortions in Wales have been able to access care that otherwise they may have struggled to obtain. ● This consultation is rightly only concerned with where the first part of an Early Medical Abortion is taken. Decisions to scan people only where indicated, and how doctors and nurses undertake clinical consultations are based on best medical practice and clinical guidelines – not on government approval. Guidance that routine scanning is not necessary to provide a safe and effective abortion service has been in place since 2011 in RCOG's Guidance for the Care of Women Requesting Induced Abortion. ● Around 60,000 women have received telemedical abortion care across Great Britain since the original approval, with no notable difference to the already low risk profile of abortion care.

Q4.	**In your experience, have other NHS Wales services been affected by the temporary approval? If so, which?** ● Data from April – July 2020 shows that less follow up care is needed for complications of abortion following the change in regulation ● BPAS data from April – July 2020 shows that less follow up care is needed for complications of abortion following the change in regulation. The proportion of EMAs with complications declined compared to the same period in 2019. ○ The risk of continuing pregnancy after treatment fell by three-quarters to 0.28%, down from 1.12% - potentially as the result of people being able to choose the best time for them to start the procedure, rather than having to fit it

	around their commitments in addition to the in-clinic appointment for the first medication ○ The same data shows that the risk of major complication (usually the only kind of complication that need hospital care) fell by 2/3rds from 0.09% to 0.03% ● The reduction in mean gestation means more people are able to access early medical abortion, reducing the need for surgical services and releasing capacity for other medical procedures ● In Wales, some services operate with only one doctor – meaning that those seeking abortions had previously needed either to attend the clinic repeatedly, or attend another service such as GP to obtain the two signatures required by the 1967 Abortion Act.

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.** No, there is no clinical benefit to having a statutory blanket requirement for women to make at least one visit to a service: the evidence presented in this consultation response shows that a remote service is as safe and as effective as an in-person service. Requiring people seeking abortions to make at least one in-person visit for a clinical assessment is neither necessary nor beneficial. ● Every person seeking an abortion is asked by abortion providers whether they are safe at home. This is a routine part of abortion care, no matter how or where care is provided. For instance, one NHS service in Wales gives patients a safe word in their first interaction so they can raise concerns in the event they are not able to find somewhere private to speak. ● Some people seeking access to services are in relationships or home environments where their behaviour and travel are monitored – meaning travelling to an abortion clinic is difficult or dangerous. Telemedicine enables these people to access abortion care without risking their personal safety. ● People in difficult circumstances are now more likely to seek regulated care and support in the knowledge that they will not be forced to travel to a clinic to access that help – the online pill provider Women on Web, which frequently received requests

	from people in coercive or controlling relationships, reports they are now able to access legal care. ● Abortion services continue to provide in-person care when clinically indicated, for clients who feel they need them, and for those about whom providers have safeguarding concerns, such as safety or privacy at home, ability to consent, or wider safety concerns surrounding existing children. Making recent regulatory changes permanent would not change this. ● Abortion providers report that providing care remotely led to increases in the number of people disclosing problems at home. BPAS reported that in the first three months of their Pills by Post service, 10% of clients underwent an enhanced safeguarding risk assessment – a 12% increase compared to March 2020. ● Clinicians providing abortion services report that telemedicine has made people more willing to disclose concerns about safety when in the privacy and familiarity of their own surroundings, as opposed to a clinical environment ● Data from MSI Reproductive Choices UK (Erlank et al., 2021) showing that 95.3% of respondents felt that they could talk privately. None reported that they could not consult privately. The flexibility of a hybrid model, where people seeking abortions have the choice of either telemedical and in-person consultations would allow for greatest access, particularly for those who are most vulnerable.

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?** **Age** – younger people and those aged under 18 are disproportionately likely to be unable to travel for healthcare, as a result of lack of access to private transport, or the money to travel on public transport. During the pandemic, sizeable numbers of those seeking abortions were student-aged, living at home with their parents and seeking to conceal their pregnancy and abortion. Telemedical abortion services increase accessibility for this group, and enable them to better preserve their privacy.

	Pregnancy or on maternity leave – This consultation should focus on the needs of pregnant people – and their ability to access evidence-based care as per best clinical practice, rather than access care based on unwarranted and unnecessary government regulation. **Disability** – People with both physical disabilities and certain mental health issues may struggle to access in-person medical care, particularly where they don't have their own means of transport or require an escort to attend a clinic. Some people may be unable to travel at all. Without telemedicine, there is a real risk that these people are forced to turn to illegal online options because they cannot access care within the formal healthcare system. **Race and Religion/Belief** - Members of all communities in the UK access abortion services, even where their cultural or religious background disagrees with abortion access. These people are disproportionately likely to need to access care privately and without the need to travel – which is only ultimately available via telemedicine. **Sex** – 1 in 3 women will access abortion care during their life. The legal provisions surrounding the accessibility of care are a fundamental part of women's healthcare and the exercise of women's rights in this country. Abortion should not be subject to unnecessary, politically-driven restrictions which are not in place for other forms of gender-neutral healthcare. Women have the right to access abortion, and should have the right to access high-quality, evidence-based care.

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?** There are many hidden costs to accessing in-person abortion care services, including child-care, organising time off work, and travel. As per DHSC 2019 Abortion Statistics in England and Wales, there is a strong association between deprivation and abortion, with the rate in the most deprived decile (26.1 per 1000 women) being more than double the rate in the least deprived decile (12.20 per 1000 women).

We also know from national statistics that the most economically disadvantaged are more likely to rely on benefits, less likely to have access to private transport, more likely to work in jobs with poor benefits or zero-hour contracts where sick pay is minimal or non-existent, and less likely to be able to afford childcare. If all those who seek abortions are required to attend clinics, it is the most deprived people who will be put in the most difficult position.

Abortion providers report that people on lower incomes may often struggle to access clinics – asking providers to delay appointments until they are next paid so that they can afford to travel. This delays their appointments and increases average gestation – increasing their risk of complications. This is supported by Scottish abortion figures which show that people in more deprived circumstances are disproportionately likely to have later abortions.

Q8.

Should the temporary measure enabling home use of both pills for EMA:

1. **Become a permanent measure? YES**

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]? N/A**

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:

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.

	Yes, anything that gives women more choice and freedom over their choices with prganacy and abortion is a positive thing. Enabling women to take procedures at home lessens the barriers of accessing medical settings.
	Most definitely. Women are receiving a better service in a timely manner. They are in control of when they are able to commence their treatment in a safe environment. They do not have to spend a long time in a clinical area and have a return journey.
	Yes. Allowing women to access services from home increases their choice and respects their privacy
	I think that women having a termination is a very personal experience and that the temporary approval of women being able to carry out the process by tablet in the comfort of their own own, with support and privacy is a good thing, however the need for professional support is extremely limited and difficult to access after the process. It seems as if you make the choice and you are expected to get on with it without professional support. A lot of women and their partners have many questions and emotions after the process and though being at home during the process of termination, it's the after math that requires just as much support and information as the initial termination decision.
	Yes. Removes an obstacle to timely treatment.
	There is no doubt the temporary approval has had a very positive impact on services. the best marker of this is the reduction in time clients need to wait to be seen by a providor and therefore a reduction in late gestation terminations.this adds to safety
	As a doctor who has been able to offer this treatment option in Wales, I fully support it as a safe and effective. I have seen several patients for whom it has made abortion possible, whereas subsequent hospital attendance would not have been viable. It is accessible and convenient, and it would be a great loss were it withdrawn.
	How can it be safe,women are lying abt how far they are in pregnancy risking their own life as well as the baby's.
	Vulnerable women can be forced into taking abortion pills. With the exponential increase in the incidents of domestic violence during lockdown, many women will have been forced into requesting such abortion pills. Abused women could be coerced into carrying out the abortion with only their abuser present. Such women would be unable to phone for medical help because the abuser would hear.
	It is obviously not safe for women to carry out a DIY abortion at home as they do not have immediate access to medical care. Also, there have been insufficient checks on how old the unborn child was - when it's mother took abortion pills. Police have had to investigate the death of both a newborn baby and a baby over 28 weeks gestation allegedly killed by pills through the post. With a spike in domestic abuse during lockdown - women could be coerced into ordering abortion pills and carrying out the procedure by their abusive partner. There is insufficient protection of these vulnerable women.
	No. It is less safe. All abortions, of course, to be abortions, must be unsafe for the unborn child. But with home abortion without medical assistance being readily available, the mother is also vulnerable, especially in an abusive or domestic violence situation. It is impossible to detect co-erced abortions, for instance. A lifetime of regret and/or post-abortion symptoms (grief, nightmares, suicidal thoughts, depression, low self-esteem, guilt, panic attacks, anxiety, etc.) may follow an abortion of any type: with a home abortion, and seeing, and having to dispose of, what results, these things might be even worse. Asking a woman or perhaps teenage girl to wrap up the ""products"" and dispose of in the rubbish or flushed down the toilet is asking her to experience something potentially horrific, considering that MPs and the Guardian newspaper objected to the ""shock tactics"" of sending PLASTIC MODELS of preborn children to political representatives. Are inexperienced girls blithely expected to deal with the REAL THING? It is also an infringement of the human rights of ordinary citizens to be asked to come across such things without their asking in the course of their everyday work. Dwr Cymru have so far given no guidance to myself concerning their policy of advocating that nothing be put down the toilet except human excreta and toilet paper. A man unblocking a drain confided in me that sanitary towels down the toilet are a major source of blockage. What about a very young, if admittedly very small, human being, exactly as the reader of this was at that age?
	The question is irrelevant. Abortion is an abomination under any circumstances. Remote 'consultation' means that there can be no effective ascertainment of the circumstances of the pregnancy. Major abortion providers have been sending pills through the post without any proper checks on the circumstances of the woman and her pregnancy. This is a fact. We know it. ""Pills through the post"" have the effect of enabling abuse of women by controlling partners who coerce them into having abortions. This is all the more prevalent at the present time, in line with the increase in cases of domestic abuse on account of the coronavirus pandemic.
	No, as do it yourself abortions are very dangerous as they are impossible to regulate effectively, putting mothers futher at risk. In England, police have investigated the deaths of a new-born baby and a bay at 28 weeks

	gestation after their mothers took abortion pills sent in the post well past the legal limit. Abortion providers are sending women abortion pills without proper checks. These lax practices put women further at risk.
	I do not think that the new at home option provided due to the pandemic has had a positive impact regarding the safety of the women concerned. Consider the number that died from complications following the use of said abortion services.
	No. I don't believe there is enough thorough consultation with the mother concerned.
	Hard to regulate any DIY activity Vulnerable women could be forced
	No it's not safe at all for either mum/ baby. Mum is risking her life and murdering her child at the same time.
	No. Absolutely not. It is well known that these earlier pregnancy methods of termination can be even more traumatic for the mother because it is the only abortion procedure where she may come face to face with her child- often women see the embryo/fetus and are horrified at how developed it is so early on. This stays with women forever. There's enough mental health consequences to the pandemic without this also. Also, monitoring of the mother will be non existent putting her in danger - as seen by the deaths that took place in the UK soon after this was permitted. It will also lead to more abortions which is bad for the child, the mother, the NHS, the family unit and society and morality at large.
	There is absolutely no way to guarantee that the pills provided will be used by the person who made the request or that the pregnancy is within the legal limits of less than 9 weeks 6 days gestation. There is also the possibility that a women is being coerced by an abusive partner, so safety is missing in both these cases.
	No. Home abortions without any medical or counselling supervision are very dangerous. It is effectively going to back before the 1967 abortion act when ""backstreet abortions"" were so notorious for hurting women.
	DIY abortions are impossible to regulate effectively. Pills could be sent out without necessary checks. The pills could get into the wrong hands ie men or women who want to poison or hurt another woman and a child could even get them accidentally. Vulnerable women could be forced to take the pills and this is especially true due to the increase in domestic abuse during the pandemic. A woman could be in deep distress and having to see the expelled foetus with only the abuser present. There would be no way of telling if it was genuine on the womans part and she cant call for help as her abuser would hear.
	Please find below a link to an article entitled ""The Year of the Abortion"" which I recently located from the Conservative Woman website. The article highlights the devastating impact to women who have undergone medical abortions. It also includes a harrowing and tragic testimony of one woman, who undertook a medical abortion in her own bathroom. The Year of the Abortion https://conservativewoman.co.uk/the-year-of-the-abortion/
	No. There has been a reduction in meaningful engagement with medical personnel and an increase in the onus on the woman in selecting an abortion as the best route available. No regard is made for the safety or right to life of the child.
	Medical abortion at home makes the deliberate ending of a human life easy. The woman involved has reduced access to ultra-sound where she would have abundant opportunity reflect on the tragic seriousness of what action she is about to wilfully execute and just who she is about to wilfully execute. The impact of this action can have a lifetime of negative emotional impact on the woman involved and her family as well as the tragic loss of human life and cheapening of life itself. The woman has less access to rapid medical care if the procedure goes wrong as it has in the deaths of two women who took the pills, plus who knows how many other cases of physical damage which have not been given media attention.
	Medical abortion at home makes the deliberate ending of a human life easy. The woman involved has reduced access to ultra-sound where she would have abundant opportunity reflect on the tragic seriousness of what action she is about to wilfully execute and just who she is about to wilfully execute. The impact of this action can have a lifetime of negative emotional impact on the woman involved and her family as well as the tragic loss of human life and cheapening of life itself. The woman has less access to rapid medical care if the procedure goes wrong as it has in the deaths of two women who took the pills, plus who knows how many other cases of physical damage which have not been given media attention.
	Where abortion pills are supplied by post after online or telephone consultation there is no medical evidence as to the stage of pregnancy that a woman has reached. She may be genuinely mistaken about her stage of pregnancy or concealing it in order to receive the medical abortion. If the gestation period is beyond the period of 9 weeks and 6 days women are far more likely to risk serious complications to their health and well being, There is also the risk that a woman may be coerced into taking abortion medication if she is already in a dangerous abusive relationship and unable to seek proper medical advice if complications arise. Without face to face consultation an abusive home situation may be concealed from the abortion provider.
	No. These services can be very unsafe, and if something were to go wrong there could be very serious consequences for any women undergoing this treatment.
	This temporary approval will not have positive impact on abortion services. Who is to check on who is subscribing to the service ? What if the procedure goes wrong in private and no help for the women/girl who needs medical help?The whole process of 'DIY' abortion seems ill- thought out , and a panic reaction the the present crisis in NHS services. We can do better than that surely.

	I believe the temporary approval of home abortions has had a negative impact on the provision of abortion services. A remote consultation cannot possibly replace a person to person consultation because the patient is forgoing a physical examination to guarantee 1st trimester pregnancy.
	Sending any pills by post without proper health checks had to be unsafe.. sending abortion pills by post without proper health checks is madness. Women in vulnerable domestic situations could be coerced into taking the pills. I've read of a police investigation into one baby death . The practice is impossible to regulate.
	No. From a health care professional and moral point of view this could be dangerous for several reasons. 1. it can lead to unduly easy access to women or girls who ate misinformed and lack of guidance. 2.in cases of complications, it poses dangers as ghere is no medical guidance at home. 3. vulnerable women or young girls are at increasing risk of coersion. 4.maybe deemed as DIY "easy fix" solution instead of careful thinking of consequences physically and psychologically. .
	NO. Anything that goes on outside of a Doctor's surgery/Hospital is immediately open to abuse. When women have this facility for taking a pill at home then this is just aiding abusers of every kind.Many women and children are used for all sorts of evil abuse and that includes the male/female adults either living in their home, parents or those in in charge of them. Women whose husbands are control freaks and they are increasing by the day, make women's lives a misery without giving them Abortion Services to aid their abuse. Actually Medical Doctors are there to SAVE lives not destroy them and THEY SHOULD BE GIVEN A CHOICE ON WHETHER OR NOT THEY WISH TO BE PART OF ANY KIND OF ABORTION AS PER THEIR CONSCIENCES WHETHER RELIGIOUS OR OTHERWISE.
	Safety cannot possibly be provided for women aborting by means of abortion pills. It cannot be effectively monitored. The gestation period cannot be checked, in England, for example, there have been numerous instances where mothers have taken the pills considerably past 9 weeks and 6 days. Mothers have been hospitalised and some died as a result of home abortions. There is also the real danger that women might be forced into abortion by abusive partners against their will, the instance of domestic abuse has increased in lockdown, putting even more women at risk.
	easy access to abortion will cause more harm than you think, human life is priceless and we are not in charge to decide whether to have an abortion or not, it's all in hands of God - he gives life and also terminates it whether you believe or not - you must not allow to kill unborn babies in the name of the law!
	AS a professional health care worker I have become concerned about the reports of women who have accessed the service and then become psychologically distressed. I do not think there has been enough consideration to a women's psychological safety. The service may be convenient and accessible but although the medical procedure is relatively straight forward the psychological impact may and often is not. A women's safeguarding should be seriously considered.
	Vulnerable women can be forced into taking abortion pills. With the spike in domestic abuse during lockdown, many women will have been forced into ordering abortion pills. Abused women could be coerced into carrying out the abortion with only their abuser present. Such women would be unable to phone for medical help because the abuser would hear.
	No, becuase it is very dangerous, unwanted complications could occur which could be irreversible
	No, becuase it is very dangerous, unwanted complications could occur which could be irrrversible.
	Regulating DIY abortions. A key safety issue is that DIY abortion is impossible to regulate effectively. In England, police have investigated the deaths of a newborn baby1 and a baby at 28 weeks gestation2 after their mothers took abortion pills sent in the post well past the legal limit. A mystery shopper exercise also revealed that abortion providers are sending women abortion pills without proper checks.3 These lax practices put women at risk. • Vulnerable women can be forced into taking abortion pills. With the spike in domestic abuse during lockdown, many women will have been forced into ordering abortion pills. Abused women could be coerced into carrying out the abortion with only their abuser present. Such women would be unable to phone for medical help because the abuser would hear.
	No. Too easy to access therefore allowing women to complete the process who otherwise wouldn't. Women are no longer receiving the emotional support to consider their options before hand and the long term effects of their decision later.
	I am concerned that even in 'normal' times abortion services are not balanced in their advice and do not give women and girls enough choice or advice about bringing their pregnancy to full term, but rather are quick to advise and facilitate abortion of their baby. The ability to access home abortion pills via the internet means that proper checks and consultations cannot take place. This means that women and girls can more easily falsify their details and pills may be dispensed for late term abortions . This could be dangerous to mothers and obviously the baby will be killed or may even be born alive causing even more distress to the mother. I am not happy that this medical procedure can be carried out by unqualified, non medically trained people. So my answer is no, this is NOT a positive move.
	No, I think that provision of abortion services without confidential, face to face discussion could not have a positive impact especially on women's safety. If abortion pills service is provided easier (no need to attend appointment in person) the safety aspect can not bee considered only in C-19 aspect. Even though from covid point of view this could be deemed safer then from mental and physical health, emotional state, individual patient's wellbeing and safety point of view such practice is much more risky.
	No A large Swedish study17 has suggested that a shift to home abortions is the reason complications for medical

	abortion have doubled in six years. The study, published in Boston Medical Center Women's Health, concludes: "The rate of complications associated with medical abortions [at less than12 weeks' gestation] has increased from 4.2% in 2008 to 8.2%i n 2015. The cause of this is unknown but it may be associated with a shift from hospital to home medical abortions. Many studies show that women experience emotional distress after an abortion and many other studies show mental health problems for women after abortion. Most research on women's abortion experiences does not distinguish between methods of abortion.18 However, a medical abortion is a drawn out process that involves a degree and type of physical suffering quite different to a surgical abortion, the complications are more frequent, and women many complete the abortion in a setting without medical care. This may lead to more adverse psychological consequences, in part because a woman may be alone when she aborts and will also likely see the foetus who is expelled. Domestic abuse is strongly associated with abortion. Intimate partner violence (IPV) is a risk factor for abortion all over the world. Removing the provision of abortion pills from a medical setting increases the opportunity for abusive partners to force women into having abortions. The problem has become more acute with COVID.
	No - it seems impossible to regulate access effectively (gestation, excluding coercion of the women seeking this by partners/families, etc.). While undoubtedly convenient, this is not safe for women.
	No Terminations need medical supervision
	With regard to safety, this was definitely a backward step. Sadly abortions have happened beyond the timescale indicated and this puts a mum's life in even greater jeopardy. Having spontaneously aborted my first baby at just over ten weeks, I can say that I would not wish this on any woman. My experience was not unlike that of a woman losing her baby at home as I was left entirely on my own, despite being in hospital. It was physically very painful, I have had four deliveries without pain relief since, and I can tell you that my spontaneous abortion was the worst, a lady who kindly came to my bedside later told me I would find a fullterm labour easier and she was right. The fear of the unknown, compounded by the knowledge that a baby has died, is not something I would want anyone to go through on their own as I did. 30 years on I still grieve, and I would have benefitted from having someone with me at the time. Having said that, I'm not sure I would have wanted someone with me who didn't value the life of my baby. So thankful for the kind doctor who visited me at home before I went to hospital. Since there is only a requirement for the health worker on the end of the phone to take the word of the mum requesting an abortion, there is little safeguarding to stop a mum having an abortion after 9 weeks and 6 days, and there is firm evidence that this has happened in the current 'emergency' situation. This again puts the mum's life at greater risk. It's not difficult to imagine the situation where an abusive partner puts pressure on a mum to have an abortion, and sits there while the phonecall is made, to make sure the pills are supplied, how would the health worker be sure that such coercion is not happening. The possibilities are appalling and obvious, and no healthworker should be put in this position. Doctors in particular have taken an oath to preserve life and to not endanger it. Many people are well aware how difficult it is for abused women to go against the wishes of the abuser. This danger alone should be sufficient to return abortion legislation to the pre-Covid measures. Abortion is such a serious decision that 'convenience' shouldn't even enter into the discussion. The government has had great difficulty deciding how to get vitamin D to a vulnerable population during the pandemic, a routine and wildly-recognised beneficial and frequently deficient vitamin, and yet it would appear that early pregnancy abortifacients were more readily available to those who asked. Taking all the above into consideration, making such abortifacients more accessible is not positive for women. We restrict the accessibility of paracetamol, recognising that people under stress may make a decision they might regret and should be helped to take time, and yet we would post out abortion agents, with potentially life-threatening consequences to mums under stress, they don't even have to go to the pharmacy.
	Negative impact with regard to safety, through the reduction in proper advice and consultation over a serious and far-reaching decision
	No, I believe that it has had a negative impact with regard to safety, i have heard of women dying. Abortions have been done illegally, after the recommended date and with no proper counselling women may have had an abortion without due regard to alternative help.
	No, from what I have read of coverage there is the potential that it has had a negative impact with regard to safety. The lack of checks over protections for the woman involved for health and pressures on her.
	No. There have been a number of cases where women have suffered adversely from the lack of medical oversight, including at least one death.
	No, I do not believe it has. Abortion for whatever reason is not a matter to be taken lightly and always results in significant mental and emotional duress for the woman concerned. The provision of abortion without an in-person appointment significantly alters the environment in which women make life-changing decisions about their pregnancies and the future of their unborn child. I believe both women and unborn children are of immense value, and women should not be making these decisions, alone, at the end of a phone call. There also remain practical issues like disposal of the foetus and attending to any subsequent complications, like bleeding. The resultant emotional scars for the woman and man, can be life-changing.
	No, I believe it has had a negative impact in terms of safety for women.
	Whilst I am sure that some women may find it more convenient I believe that it is less safe than a face to face meeting. Attending an in-person appointment where all aspects can be explored and where the health professional is in a better position to assess the women needing advice and support.
	No it has a negative impact on the woman's safety

	No, it has had a negative impact with regard to safety. Whilst it is accessible and convenient there is no personal face to face consultancy and things can go wrong with the actual procedure.
	I believe that temporary approval has had a negative impact as this is not a safe way to go about such a life-changing event in a woman's life and does not give time for proper consultation or thought.
	On balance, no because I think that the telemedicine approach to providing abortion services only delivers a physical solution and does not provide holistic care which is necessary when considering the termination of a life. In addition, it also increases the physical harm which could follow from the abortion as the procedure is not followed up and is not always safe. I'm sure, in some instances, women who would have struggled to seek an abortion, have found this service much more accessible, but I'm not convinced that it is the best way of providing care for women in such a vulnerable time of their lives.
	1. No it is less safe that when done under medical guidance and regulating the abortions is not possible and that is the key safety issue. In England, police have investigated the deaths of a newborn baby and a baby at 28 weeks gestation after their mothers took abortion pills sent in the post well past the legal limit. A mystery shopper exercise also revealed that abortion providers are sending women abortion pills without proper checks. These lax practices put women at risk and it is going unregulated in the current situation. 2. Vulnerable women can be forced into taking abortion pills. With the spike in domestic abuse during lockdown, many women will have been forced into ordering abortion pills. Abused women could be coerced into carrying out the abortion with only their abuser present. Such women would be unable to phone for medical help because the abuser would hear.
	Concerned about safety
	No, it has had a negative impact with regard to safety.
	I feel that even though it allows ladies to avoid seeing others whilst in this pandemic I feel it is very dangerous especially only needing to have a phone consultation to allow them to gain such a dangerous medication. I feel that as a person you dont know who is gaining this medication and if it is for the right reason or person.
	No. I think that safety is an issue whenever a life changing medical procedure is made. Also the consultation over such procedures, perhaps especially this one, regarding mental health over the issue is of equal importance to the physical aspect. Certainly more important than 'accessibility and convenience.'
	No, it has had a negative impact. Without a medical consultation to determine gestation, genuine mistakes can be made. Women may not realise the danger and distress which could be caused to themselves by understating their gestation, or in not following the instructions for taking the abortion tablets fully or promptly. A medical examination could also discover complications with the pregnancy which require further or different help. Time can also be taken to discuss and explain side effects, and even, possible alternatives to a termination. Women who are victims of domestic violence may get help and support at such an appointment also.
	No, it has had a negative impact with regard to safety. I believe the babys life is being ended and that is not safe and the mother is put at risk medically and emotionally. She may be coerced into medical abortion by an abusive partner and feel she has no choice.
	No,it has not been an advantage. Women face greater risks from the pressure of others and the lack of medical consultation.
	NO It is very difficult, if not impossible, to verify home abortions are being carried out safely.
	No, it has had a negative impact with regard to safety.
	No, it has had a negative impact with regards to safety.
	No Increased safety risks in physical health for women who have complications at home, increased risks for the mental health of women who have an abortion at home and have to deal with the abortion physically in terms of disposing of the aborted foetus and also not having access to the support necessary after they have an abortion. With the whole process being dealt with at home and possible making it easier to access an abortion then abortions could be accessed at a time when it is not medically safe for women or legally within the law. However, it also limits a woman’s access to the necessary support services after she has an abortion. Younger girls could access abortion services without adequate checks. Women may feel pressurised into abortions by abusive partners and this risk cannot be assessed in telephone consultations.
	No, I think it is very dangerous, as it is not possible to regulate effectively. There are ongoing investigations, in UK, into the death of a newborn baby, and a baby born at 28 weeks. Their mothers had taken the abortion pills well past the limit. Apparently pills are being posted without proper checks, thus endangering women and girls. Vulnerable women can be forced into taking abortion pills. As a midwife, I have seen the power partners and family can have over women and girls. With the rise in domestic abuse in the pandemic, a valuable occasion, for those affected to be seen, assessed and helped by a healthcare professional, will be lost.
	No, there have been a number of cases where the opposite is in fact true. Women have not had access to proper care and been able to discuss the issue with a healthcare professional. There is a lack of proper consideration about the short-term physical impact and any long-term physical and psychological impact of abortion on mothers. In addition, as is always the case in abortion, the unborn children involved are given no voice at all.
	The drugs dispensed under the present arrangement are necessarily powerful agents with the potential for causing severe side effects. Women requesting abortifacients over the 'phone may be experiencing varying degrees of stress in what may be, less than ideal domestic situations.There is a risk that these drugs could be

	accessed by other household members, such as children or dementia sufferers. I consider that the despatch of these potentially harmful agents through the post (or by any other method) without a prior,confidential face to face consultation with a suitably qualified person and without an actual medical examination, to be grossly irresponsible.
	No. The temporary approval has had a detrimental impact in many cases causing great issues of safety to women's physical and mental health. There is no means of regulating the point at which abortion may be carried out, and the is much evidence (anecdotal and recorded) of very late abortions being carried out in private homes.
	A discrace not only putting lives at risk wouldn't it be better to provide free contraception
	I think we all have experienced the mental health difficulties of isolation during the COVID 19 crisis. I am concerned that vulnerable women will have less opportunity to talk to someone. Abortion on one's own will be a traumatic experience in itself (being isolated and alone), but it is a decision that could affect her long term mental health. It seems reasonable that more consultation can only help.
	It has had a negative impact. Home abortion is a painful and traumatic experience for women. Women may take the abortion pills past the 10-week limit – the abortion provider cannot correctly assess how far along the woman is in her pregnancy without the usual scans. Pills by post requires the woman to be accurate in her recall of the first day of her last period in order to assess gestational age, and puts that responsibility squarely on the pregnant woman. Vulnerable women can be forced into taking abortion pills. Providers are unable to check that woman is not being coerced. There is not a safe private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure. Providers cannot confirm the identity of the woman requesting abortion pills – in our mystery client investigation, in 26 cases out of 26, our team was able to obtain the abortion pills by post, even though they provided false information and were not pregnant. In a leaked email sent by a senior midwife at the NHS, a number of concerns were highlighted, including 13 related incidents including the delivery of a baby at 30 weeks gestation, 3 police investigations, one of which is a murder investigation as there is a concern that the baby was liveborn. The Department of Health and Social Care revealed it had been notified of 52 women who had been prescribed the pills for abortion at home in the first six months of the policy, where gestational age was beyond the 10-week limit. Where cost is a barrier to attending the clinic in person, we recommend that financial assistance should be provided by the NHS to enable an in-person consultation.
	as most abortions are the result of unprotected sex the issue should be one stage back. legislation providing education and teaching proper moral standards as well as enforcing the law on sexual activities for children would be a good start. 16 is probably still too young for teens to have sex but until the current law is enforced and education services start to teach moral standards this situation will not improve. Prosecution of children who break this law should be enforced so we turn the tide on the immorality that is rampant today.
	No. Women's safety should not be compromised by allowing abortions to take place without the supervision and clinical care equivalent to that provided by a hospital.
	No I think women need time to discuss and reflect on the decision they are going to be making and this should be done face to face. It has a negative effect on safety.
	I was an intensive care sister and I am appalled that the home abortion scheme would be considered safe. We know from studies that 1 in 5 women suffer complications taking a combination of two pills. To self administer at home in my opinion is very risky for the women. There can be haemorrhaging and infection that could lead to sepsis. It just is not safe. Women are only safe where there is supervision and the clinical care is the same as you get in a hospital.
	It has had a negative impact. Home abortion is a painful and traumatic experience for women. Women may take the abortion pills past the 10-week limit – the abortion provider cannot correctly assess how far along the woman is in her pregnancy without the usual scans. Pills by post requires the woman to be accurate in her recall of the first day of her last period in order to assess gestational age, and puts that responsibility squarely on the pregnant woman. Vulnerable women can be forced into taking abortion pills. Providers are unable to check that woman is not being coerced. There is not a safe private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure. Providers cannot confirm the identity of the woman requesting abortion pills – in our mystery client investigation, in 26 cases out of 26, our team was able to obtain the abortion pills by post, even though they provided false information and were not pregnant. In a leaked email sent by a senior midwife at the NHS, a number of concerns were highlighted, including 13 related incidents including the delivery of a baby at 30 weeks gestation, 3 police investigations, one of which is a murder investigation as there is a concern that the baby was liveborn. The Department of Health and Social Care revealed it had been notified of 52 women who had been prescribed the pills for abortion at home in the first six months of the policy, where gestational age was beyond the 10-week limit. Where cost is a barrier to attending the clinic in person, we recommend that financial assistance should be provided by the NHS to enable an in-person consultation.
	Don't allow abortions to take place at home, it isn't safe.

	It has had a negative impact. Home abortion is a painful and traumatic experience for women. Women may take the abortion pills past the 10-week limit – the abortion provider cannot correctly assess how far along the woman is in her pregnancy without the usual scans. Pills by post requires the woman to be accurate in her recall of the first day of her last period in order to assess gestational age, and puts that responsibility squarely on the pregnant woman. Vulnerable women can be forced into taking abortion pills. Providers are unable to check that woman is not being coerced. There is not a safe private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure. Providers cannot confirm the identity of the woman requesting abortion pills – in a mystery client investigation, in 26 cases out of 26, the team was able to obtain the abortion pills by post, even though they provided false information and were not pregnant. In a leaked email sent by a senior midwife at the NHS, a number of concerns were highlighted, including 13 related incidents including the delivery of a baby at 30 weeks gestation, 3 police investigations, one of which is a murder investigation as there is a concern that the baby was liveborn. The Department of Health and Social Care revealed it had been notified of 52 women who had been prescribed the pills for abortion at home in the first six months of the policy, where gestational age was beyond the 10-week limit. Where cost is a barrier to attending the clinic in person, we recommend that financial assistance should be provided by the NHS to enable an in-person consultation.
	Dw i o'r farn na ddylid cyfaddawdu ar ddiogelwch menywod drwy ganiatau i erthylu ddigwydd heb arolygaeth na'r hyn sy'n gyfystyr a gofal clinigol tebyg i'r hyn a ddarperir gan ysbytai. Pan fo erthylu'n digwydd gall pob math o gymhlethdodau godi, megis colli gwaed a heintio. Gall sefyllfaoedd o'r fath adael menywod agored i niwed heb gynhaliaeth ac ar adeg pan fo llawer yn mynd trwy brofiadau emosiynol mawr yn dilyn erthyliad. Mae ystadegau'n dangos bod 81% o risg uwch o afiechyd meddyliol yn dilyn erthyliad.
	I believe that women's safety should not be compromised by allowing abortions to take place without the supervision and clinical care equivalent to that provided by a hospital as there can be medical complications such as haemorrhaging and infection. Home abortions can leave vulnerable women with little support as studies have repeatedly shown that women experience emotional distress after an abortion.
	Nac ydwyf. Mae wedi peryglu diogelwch ac iechyd meddwl menywod drwy adael i erthylu ddigwydd heb ofal meddygol sydd yn gyfartal â'r hyn a geir mewn ysbyty. Datgelwyd y peryglon o'r fath mewn ebost gan brif fydwraig ranbarthol yn Lloegr yn ddiweddar, er enghraifft, a dangosodd un astudiaeth mai un ym mhob pump o fenywod sydd wedi dioddef o gymhlethdodau ar ôl cael erthyliad meddygol. Gwelwyd hefyd adroddiadau am fethiannau yn y system a arweiniodd at roi cyffuriau erthylu i fenywod a oedd y tu hwnt i'r terfyn beichiogrwydd a argymhellir er mwyn cael erthyliad.
	Women's safety should not be compromised by allowing abortions to take place without the supervision and clinical care equivalent to that provided by a doctor.
	I think it could be unsafe for ladies to have unsupervised abortions at home. There can be complications that could be easily remedied in a medical setting but would be difficult to quickly treat in the home setting; for example haemorrhage and sepsis. I also worry about ladies that have mental health issues because abortion can increase this risk considerably; from a report by P K Coleman found in the British Journal of Psychiatry 199(3), 2011
	This measure was introduced as an emergency in the Covid 19 pandemic No open debate was allowed for the Welsh government members to debate the whole principal of Home Abortion .There must be a full discussion of the effects on the expectant mother and the rights of the unborn child .The present arrangement should end .
	A key safety issue is that DIY abortion is impossible to regulate effectively. In England, police have investigated the deaths of a newborn baby1 and a baby at 28 weeks gestation2 after their mothers took abortion pills sent in the post well past the legal limit. A mystery shopper exercise also revealed that abortion providers are sending women abortion pills without proper checks.3 These lax practices put women at risk. • Vulnerable women can be forced into taking abortion pills. With the spike in domestic abuse during lockdown, many women will have been forced into ordering abortion pills. Abused women could be coerced into carrying out the abortion with only their abuser present. Such women would be unable to phone for medical help due to the abuser being present.
	Women's safety could be in danger should she abort without the expertise that a hospital can provide.
	No has had a negative impact. Home abortion is a painful and traumatic experience for women. Women may take the abortion pills past the 10-week limit – the abortion provider cannot correctly assess how far along the woman is in her pregnancy without the usual scans. Pills by post requires the woman to be accurate in her recall of the first day of her last period in order to assess gestational age, and puts that responsibility squarely on the pregnant woman. Vulnerable women can be forced into taking abortion pills. Providers are unable to check that woman is not being coerced. There is not a safe private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure.

	Providers cannot confirm the identity of the woman requesting abortion pills – in our mystery client investigation, in 26 cases out of 26, our team was able to obtain the abortion pills by post, even though they provided false information and were not pregnant. In a leaked email sent by a senior midwife at the NHS, a number of concerns were highlighted, including 13 related incidents including the delivery of a baby at 30 weeks gestation, 3 police investigations, one of which is a murder investigation as there is a concern that the baby was liveborn. The Department of Health and Social Care revealed it had been notified of 52 women who had been prescribed the pills for abortion at home in the first six months of the policy, where gestational age was beyond the 10-week limit. Where cost is a barrier to attending the clinic in person, we recommend that financial assistance should be provided by the NHS to enable an in-person consultation.
	No. Woman aborting their babies are at risk of medical complications, which are far better managed in clinical settings. There have been reports of serious failures with the home abortion scheme, with abortion providers prescribing pills for women well outside the recommended gestational limit, which is incomprehensible. One woman was found to have aborted her baby at 28 weeks, which, quite rightly so, prompted a police investigation. This can not be responsible clinical care. Home abortions will continue to leave vulnerable women with little support. Studies have repeatedly shown that women experience emotional distress after an abortion; so the opportunity to see a clinician and talk over this huge decision, and all the other possible options for the pregnancy, is extremely important.
	No, it is has had a negative impact on all of these. Abortions can lead to complications, so when done at home this can lead to disastrous consequences. A large study showed that up to one in five women had complications when undergoing an abortion involving the taking of two pills. It is much safer if they are within easy access of medical assistance. Compounding this are many reports of pills being too easily obtained, so abortions have been performed when they would not otherwise be allowed. Examples include: 3 police investigations where a late abortion has resulted in a live baby being born; a woman aborting her baby at 28 weeks, also resulting in a police investigation. Another negative impact is the risk of women being forced to have abortions by partners or other family members. This is also worsened by examples of people being able to obtain pills on behalf of others or even just by pretending to be pregnant. Without trained medical professionals present, there is another risk that people will not follow the correct protocols for taking the pills. Also, abortion often has a negative impact on women's mental health. This is likely to be worsened by a woman taking the pills by herself and having to dispose of the remains of the baby by herself. Many women cannot access, or feel uncomfortable accessing, medical help remotely. Also, recent polling from ComRes (http://www.comresglobal.com/wp-content/uploads/2017/05/Where-Do-They-Stand-Abortion-Survey-Data-Tables.pdf) show that women want more, not fewer, safeguards around abortion across a number of key areas. For example, 77% of women agreed that doctors should be required by law to verify in person that a patient seeking an abortion is not under pressure from a third party to undergo the abortion. Women who live far from critical care services, such as those in remote communities, are a greater risk if they have home abortions. An undercover investigation last year was able to obtain pills using false NHS numbers and unverified gestational ages. This clearly demonstrated that abortion providers do not know who they are sending abortion pills to. Without the oversight of medical professionals, there is an enhanced risk of women being coerced to have abortions. Overall, to guarantee women's safety, the current order should be reversed immediately.
	The effects of this temporary arrangement have been wholly negative. I have read many reports from women who have been deeply traumatised, and have suffered immensely, in aborting a child at home. And let's not forget that this 'service' gives women scope to take the pills, and thus have an abortion, long past the 10-week limit. In the first six months of this policy being in force, no less than 52 women have been proven to have taken these pills beyond the 10-week limit. Without proper scans, no provider really knows how far along a woman may be in her pregnancy. Without a face-to-face consultation, the system is ripe for abuse - not only by women who lie about the length of their pregnancy, but also by abusive partners who may be coercing a woman to abort, unseen by the provider. A mere telephone conversation does not have sufficient safeguards to prevent the latter scenario. Also:

	under this current arrangement, anyone can get these pills, for whatever purpose. I refer you to Christian Concern's Mystery Client Investigation (where 26 out of 26 false, bogus claims were accepted by the provider) as proof of this. There is a murder investigation ongoing as a result of this policy. Need I say anymore?
	No I believe the safety of women is compromised. Abortion has a risk of the medical complications of haemorrhage and infection. The Niininmaki et al paper 'Immediate complications after medical compared with surgical termination of pregnancy' found a complication rate of 20% from medical abortion. Woman should be not be left at home, potentially alone without the usual standard of care and supervision that would normally be provided. There have also been concerns raised in a leaked e-mail by a regional chief midwife about the 'escalating risk' of home abortion and it's complications.
	I consider 'convenience' of service to be a disaster for both woman and the unborn child. Decisions made with such speed and ease cannot take into account the long term psychological impact upon the mother in such momentous decisions.
	Not at all. The temporary approval of DIY abortion services has done nothing to safeguard either the life of the unborn or the welfare of women. Its effects have been entirely negative.
	I'm confident that the temporary approval has reduced the risk of women and girls catching the coronavirus, as they haven't had to visit a clinic. However, I believe the risk of physical and mental trauma due to the abortion process has increased, as there hasn't been the same level of clinical oversight. While the ability to receive pills through the post has increased convenience, it reduces safety as you cannot be sure the pills are definitely going to the appropriate individual, nor that they are being taken at the appropriate times.
	No there is no positive impact to any abortion, it is the murder of a human with eternal potential. There will be accountability, everyone involved actively or passively in promoting abortion will have to answer to GOD We were saved by a GP many years ago from making this dreadful choice. How many women are racked with guilt because of abortion. GOD save us from this evil
	No. The current arrangements put women at greater risk of: - taking abortion pills beyond the point at which they are legal - being coerced into abortion
	Convenience, yes. Safety, no. There have been problems following the abortion in a number of cases. The NHS in describing the risk of bleeding in medical abortions says “serious complications such as heavy bleeding, damage to the womb, or sepsis: this happens to about 1 out of 1,000 women”
	No. I have concerns about the misuse of the service, whereby women claim to be in early pregnancy but in fact are much later in pregnancy. It is very difficult to verify that the duration of the gestation of a woman's pregnancy is not beyond 12 weeks (when the uterus becomes palpable) without a clinic assessment. Late EMAH are likely to increase the risks to the mother. I also have concerns about coercive partners forcing EMAH on pregnant women which is also going to be harder to pick up without a clinic assessment. TOP is associated with adverse mental health problems, and these may be exacerbated by EMAH where the woman has to dispose of foetal material.
	No, I think the pregnancy services have failed these women by not counselling them properly. Failed to ensure that the woman requesting the drugs is mentally suited to do so and failing to give any follow up care.
	Who is it positive for - does the foetus have any say. How can safety be determined when a woman is at home, possibly on her own or with a partner who may be coercing her against her will.
	No Medical assessment is needed by qualified persons which can’t be provided adequately over the phone. Women can be more easily coerced into abortions by their partners or others
	has not had a good effect on safety of womenhas not had a positive impact
	No, it has a very negative effect. Vulnerable women may be forced to take the pills. The providers are not able to be assured of the identity of the women, and there is no careful counselling beforehand. There is no certainty that the pills won't be used too late in a pregnancy.
	No. It is being used as a mechanism to allow further deviations from the intent of the 1967 Abortion act and trivialises yet further what is actually the killing of human life. The very wording of the consultation document is biased towards a working assumption that abortion is a good thing and the less that gets in the way of it, the better. It is less safe because any help is remote.
	It has had a negative impact. Home abortion is a painful, traumatic experience. Women are often shocked at the evidence of what they have done. Providers cannot confirm the identity of the women requesting the abortion pills. Providers do not know if the woman is past the 10 week period, she may be further along. Pills by post require the woman to be accurate in her recall of the last day of her period, responsibility for the gestation age is put squarely on the women.

	Vulnerable women may be forced into taking the abortion pills. I have a friend to whom this happened. Her husband is dominating and controlling.
	Women's safety should not be compromised by allowing abortions to take place without clinical care and supervision, one study found 1 in 5 women who had medical abortions (using a combination of 2 pills) suffered complications. It is important that women are close to medical care and not home alone. There is also no one to check that the women's pregnancy is within the recommended time limit, there has been at least one instance of a women who was 28 weeks pregnant aborting her baby. Home abortion can leave women vulnerable. Women who have had an abortion are at a higher risk of mental health problems
	No. I do not see how providing powerful drugs to pregnant women without any medical input can be helpful. There is no means of checking whether the pregnancy is under 10 weeks, which is the recommended period, and anonymous women have used fake identity to obtain these drugs. There is no medical support for these mums if there are any complications after the administration of these drugs
	I should like to make it clear from the outset that I am not in favour of any kind of abortion and consider abortion to be a negative thing in the extreme. I cannot therefore countenance DIY abortion or any facet of it, and I wish simply to point out some of its inherent flaws as a contribution to halting its advance. The said approval has provided a service that may be accessible and convenient but it is certainly not safe, fundamentally because of the geographical gap between the location of the abortion providers and that of the intended abortion. Domestic circumstances and background cannot therefore be ascertained and this can easily lead to abuse, as in the case, for example, of a woman opting for a DIY abortion, either voluntarily or under pressure: she would be better off, because of the lack of proper medical supervision, if it hadn't been so easy to obtain the required medication in the first place.
	I would like to submit my deep sadness at this home abortion rule. It is dangerous for these unsupervised young girls. It is horedouse that they are pushing abortion as the easy fix to a problem. It is anything but that. There are long lasting problems, physical and mental. Let us not forget the biggest sadness of all is the ending of an innocent God given precious life!
	No, I am concerned about the negative impact especially with regards to safety. I am concerned that the women may take the pills beyond 10 weeks gestation. In the first 6 months of this policy, the Department of Health and Social Care has been informed of 52 women who had been prescribed medication for abortion at home but who were more than 10 weeks' gestation. People can easily falsify information on the phone and there may be coercion to have abortion medication.
	No, I do not. Women's safety is the most important factor, and this has been compromised by the approval of abortion pills taken at home. The home is not a safe place for a significant minority of women. Girls and women who are being abused can be forced to take abortion pills against their wishes in the privacy of the home. Child sexual abuse victims can be forced to take an abortion pill if they become pregnant without any doctor being aware of the pregnancy or the pill. It is hard for people who have never been the victims of abuse to understand how helpless women can be in their own homes. As a former abuse victim myself, I am aware that had this option been available twenty years ago, my ex husband might very well have forced me to take these pills to have an abortion. Women must have the right to a consultation alone with a doctor, and to make the decision to take the pill in a situation where an abuser is not present. This right is taken away when pills are supplied to women at home. The other factors mentioned in the question (accessilibity and convenience) are less important than safety. In any case, abortion has been readily available for years.
	The temporary measures have had a very negative impact on safety for those undergoing home abortions as they are devoid of proper and adequate medical supervision and care. Abortion at home has been much more accessible and convenient by its very nature.
	- It has had a negative impact because : - Home abortion is a painful and traumatic experience for women. - Women may take the abortion pills past the 10-week limit – the abortion provider cannot correctly assess how far along the woman is in her pregnancy without the usual scans. Pills by post requires the woman to be accurate in her recall of the first day of her last period in order to assess gestational age, and puts that responsibility squarely on the pregnant woman. -Vulnerable women can be forced into taking abortion pills. Providers are unable to check that woman is not being coerced. There is not a safe private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure. - Providers cannot confirm the identity of the woman requesting abortion pills – in our mystery client investigation, in 26 cases out of 26, our team was able to obtain the abortion pills by post, even though they provided false information and were not pregnant. - In a leaked email sent by a senior midwife at the NHS, a number of concerns were highlighted, including 13 related incidents including the delivery of a baby at 30 weeks gestation, 3 police investigations, one of which is a murder investigation as there is a concern that the baby was liveborn. - The Department of Health and Social Care revealed it had been notified of 52 women who had been prescribed the pills for abortion at home in the first six months of the policy, where gestational age was beyond the 10-week limit.

	- Where cost is a barrier to attending the clinic in person, we recommend that financial assistance should be provided by the NHS to enable an in-person consultation.
	I believe that the temporary approval has not had a positive impact on the provision of abortion services. As at home abortions cannot be monitored or policed there is no way of identifying women who are requesting abortion pills, or whether they meet the legal criteria. Independent organisations have undertaken mystery client investigations and in all cases were able to obtain abortion pills through the post although they had clearly given false information and were not pregnant. In a real-world situation there would be no way of knowing how these pills may be legally used or the consequences that result. This the above is further exemplified by the fact that a senior midwife within the NHS has highlighted over a dozen incidents including one where the delivery of the baby was at 30 weeks gestation. Further there are at least three police investigations including one concerning a baby which was liveborn. In addition to the above the Department of Health is also aware of at least 52 women who have been prescribed the pills for abortion at home where the gestation age was over the 10 week limit.
	No, I consider it has had a very negative impact. Anyone using these pills to abort a baby could suffer from bleeding and infection and should therefore be under medical supervision. Also it is a well documented fact that women can suffer mental health problems after having an abortion, to contemplate being alone and waiting to lose your baby and dispose of him/her surely adds to the trauma of the act of abortion and will cause even more mental health problems. There is also the issue that the pills have been used after the date they should have been and obviously there are no checks on this.
	Although I can see in the circumstances of COVID this has made the service more easily accessible and convenient, I have grave concerns about the safety aspect which I think is arguably the most important aspect. Both for the health of the woman in case of complications, and for mental health reasons, dealing with potentially distressing scenarios without adequate support or facilities or emotional preparation., including the disposal of the aborted foetus.
	I believe that the temporary approval has had a negative impact, particularly with regard to safety. The abortion provider sends out pills with no real knowledge of who will use them, or how. The woman may be more than ten weeks pregnant; she may be coerced into seeking an abortion; she may have health issues which could be dangerous; she may be on her own when she has the abortion, having to deal with the disposal of the dead child, and the effect it has on her. Surely accessibility and convenience are of limited importance when dealing with such an important matter as taking a child's life.
	No I do not. The availability of the home abortion removes all the safety features of the usual service. It leaves vulnerable women at the mercies of their own terror at their situation, at risk of being forced into the abortion by family/abusers. A further problem could be the use of the EMA outside of the medically proscribed timetable with the attendant risks.
	No because counselling often saves baby lives
	I consider that whilst the need for covid restrictions at this time have made this a necessary solution it should be only temporary as it has had a negative impact on the safety of women. To make this type of life affecting decision without a face to face appointment does not allow for the medical profession to really understand the motivation of the woman. She could be making a rushed move without time to think it through or all areas considered or be coerced by another person etc.
	Definitely not, I believe that especially vulnerable women can be made to have an abortion which might not be what they want. They need to be able to see a clinician and discuss their options. As it is the health of women is at risk. I also believe in the sanctity of life. No life, except for exceptional circumstances, should be terminated.
	It has had a negative impact. Home abortion is painful and traumatic for women. They could suffer significant haemorrhaging for instance, and medical help is not readily available for them. Pregnancy could be more advanced than expected with the fetus being recognisable and the woman may be very distressed if she sees the fetus. Vulnerable women can be forced to take abortion pills by abusers. Providers cannot check that woman is not being coerced. An abuser may not allow her to get help if she needs it.
	Accessibility is a concern as there is no guarantee that the pills are used for the person making the phone call to the abortion service. This leaves women who are vulnerable and already open to abuse in a position where they could be co-erced to have an abortion. Safety concerns. There is no assessment of the gestational age of the fetus. The British Pregnancy Advisory Service (BPAS) is already investigating 8 cases of the pills being used beyond 10 weeks gestation and these are the cases that authorities are aware of. Criminal charges could be brought against women. The stage of pregnancy should be assessed on a visit to the clinic, by ultrasound if necessary. (https://www.dailymail.co.uk/news/article-8349739/Police-investigate-death-unborn-baby-woman-took-abortion-drugs-home-28-weeks-pregnant.html)
	No. Safety is definitely compromised for a number of reasons. The provider cannot confirm gestation of caller's pregnancy, leading to higher risk of complications in later

	gestation. There is evidence of safety concerns. Where complications arise, the accessibility or convenience may well be a subject of regret. The provider cannot confirm the identity of women requesting abortion pills or whether she is under duress to have an abortion, so the service is open to abuse. Women may mislead without intending to. Home abortion is painful and traumatic, and the woman may may have to go through it alone or with an abusive partner. It was set up as a temporary measure while Abortion Clinics were closed during lockdown; there is no need for it now that they are open.
	Not generally, as some women may feel coerced into having a home abortion, a big risk. Further risks arise from there being no scans available or independent support to assess the gestational age of the foetus, which to be lawful should be less than 10 weeks. Nor an ID or health check on the mother.
	I believe that the unborn baby's health should be considered and seen as equal to that of the mothers, the mothers health should not be placed above the child's. As someone working in the domestic abuse sector, I'm also concerned about how many vulnerable women will be forced to abort their children by abusive partners and how this has been made all the easier through this. Furthermore, women may be left emotionally harmed as they are left without support and just given the medication.
	Not at all. I have heard reports of serious failures with the home abortion scheme. Abortion providers have prescribed pills for women well outside the recommended gestational limit. One woman was found to have aborted her baby at 28 weeks, prompting a police investigation.
	It has had a negative impact. Home abortion is a painful and traumatic experience for women. Women may take the abortion pills past the 10-week limit – the abortion provider cannot correctly assess how far along the woman is in her pregnancy without the usual scans. Pills by post requires the woman to be accurate in her recall of the first day of her last period in order to assess gestational age, and puts that responsibility squarely on the pregnant woman. Vulnerable women can be forced into taking abortion pills. Providers are unable to check that woman is not being coerced. There is not a safe private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure. Providers cannot confirm the identity of the woman requesting abortion pills – in our mystery client investigation, in 26 cases out of 26, our team was able to obtain the abortion pills by post, even though they provided false information and were not pregnant. In a leaked email sent by a senior midwife at the NHS, a number of concerns were highlighted, including 13 related incidents including the delivery of a baby at 30 weeks gestation, 3 police investigations, one of which is a murder investigation as there is a concern that the baby was liveborn. The Department of Health and Social Care revealed it had been notified of 52 women who had been prescribed the pills for abortion at home in the first six months of the policy, where gestational age was beyond the 10-week limit. Where cost is a barrier to attending the clinic in person, we recommend that financial assistance should be provided by the NHS to enable an in-person consultation.
	There should be face to face consultaions prior to such an important decision being taken and during the procedure complications could arise which may require medical assistance. During the consultaion period prescriptions can be given which may not be suitable for the individual has a proper examination may not have taken place. The health and safety of the patient should be of utmost importance.
	Her Voice is a platform for women to share their negative experiences of abortion in their own words. Because of the stories that women have shared, Her Voice believes that the current arrangements for early medical abortion at home (put in place due to Covid-19) put women's mental and physical health and safety at risk. Often, medical terminations are described as 'no worse than a bad period' and therefore it seems safe and appropriate for women to do in their own homes. That has not been the case for some women who have shared with Her Voice. They describe significant pain and fear associated with their medical termination, which no woman should have to endure alone in her own home. Ellie, who had a medical termination in a clinic, described the experience like this: "On my way to the next appointment [to take misoprostol], I was being sick all the way to the hospital. I couldn't stop being sick. The nurse came in and gave me tablets to dissolve in my mouth, but I kept being sick every time I put them in my mouth. About two hours later still nothing had happened apart from being sick. In the early afternoon, I started to experience some light cramps. Then it started to become worse. I could hardly walk and had to crawl into the bathroom. I eventually managed to get back onto the bed which I was bent over. I realised I was having contractions. The pain was unreal I was sweaty but shaking with cold." Ellie further describes needing the nurse to bring her pain medication and to help her manage the pain she was experiencing. You can read Ellie's story here: https://www.hervoice.org.uk/ellies-voice.html

	Similarly, Amy had a medical termination in hospital. Speaking of the experience she said, “two days later I went back to the hospital [to take misoprostol] where I discovered abortion was actually quite painful. It was horrifying and it was just a complete nightmare. And afterwards, the sensation of sorrow that fell over me was physically painful.” You can watch Amy tell her story here: https://www.hervoice.org.uk/amys-voice.html These women’s experiences are not isolated incidents. They had early medical terminations without clinical complications, and yet this is how they describe their experiences. It is irresponsible to allow women to experience this alone in their homes and put their safety at risk in this way.
	No, I do not think the temporary approval is a positive thing. I believe that the safety to women has been considerably compromised. And is more likely to be done rashly and regretted.
	No, it’s had a negative impact. Home abortion is traumatic and painful. Women may take the abortion pills past the 10 week limit and the abortion provider can’t correctly assess how far along the woman is in pregnancy without scanning her. Pills by post require women to be accurate in their recall if the first day of their last period in order to assess gestational age, which puts the responsibility on the pregnant women. Vulnerable women can be forced into taking abortion pills. Providers are unable to check that a woman is not being coerced. There isn’t a safe private safe for the woman to talk freely about whether she wants an abortion or is doing so under pressure. Providers can’t confirm the identity of the women requesting abortion pills. In a mystery client investigation the team were able to obtain abortion pills by post even though they provided false evidence information. Ina leaked email by a senior midwife in the NHS a number of concerns were highlighted 13 related incidents including the delivery of a baby at 30 weeks gestation and 3 police investigations (one of which was for murder as there wasn’t concern the baby was born alive). The Department of Health and Social Care was notified of 52 women who had been prescribed abortion pills for home use, in the first 6 months of the policy where the gestational age was beyond the 10 week limit. Where cost is a barrier to attending the clinic in person it is recommended that financial assistance be provided by the NHS to enable an in person consultation.
	There are negative impacts surely involved in home abortions Safety issues are involved with the absence of clinical support and supervision provided in hospitals. Haemorrhaging and infection can occur in abortions. It has been reported that abortion providers have prescribed pills for women well outside the recommended gestational period. Vulnerable women can be left with little support. Studies reveal that women who have an abortion have an 81% higher risk of experiencing mental health problems against women who have not had an abortion. This is made even worse by the situation of the woman being alone and it must be especially traumatic to expel and dispose of the baby.
	Abortions can lead to medical complications, so women should be within easy reach of medical assistance and not at home, probably alone.
	Not really no. I am concerened that the temporary approval is compromising the safety of women. Administering abortion pills at home means they are unable to access the same degree of medical care as in a clinic or hospital. Should complications arise, (haermoragging and sepsis) which is not uncommon with abortions, lives could be at risk. Furthermore, home abortion could leave vulnerable women with no support: studies have repeatedly shown that women can suffer trauma, post abortion. Abortion is a decision that should not be taken lightly. It is estimated that women who have had an abortion are 81% more likely to experience mental health issues.
	Negative impact, particularly with regard to safety. Department of Health and Social Care has noted at least 52 cases of women prescribed EMA medication to be taken at home beyond the 10 week approved 'safe' limit. In parts of UK there are ongoing investigations into deaths of women following provision of home EMA.
	No this is a really concerning practice and it needs to end. Women need medical support if/when seeking an abortion and studies have shown (please get in touch if you are unaware of these?) that 1 in 5 women suffer some sort of complication. There are examples of these being used outside the prescribed limits. This policy compromises women’s safety and needs to be reversed.
	I was horrified to learn that the Welsh Government seem to think that letting women do these abortions at home. They don't seem to care that abortion is a very risky thing to do without any medical staff present. All things could go wrong - we are not all made the same!! I would be horrified if they give their consent to this! If things did go wrong (as abortions are not as quick and easy as some may think) you would be responsible for putting a person's life at risk!
	Not at all, I think that women’s safety has been seriously compromised as they haven’t seen a doctor, may have medical issues, could face complications such as haemorrhaging or infection and could face serious mental health issues afterwards as they haven’t had opportunity to talk through what they’re doing.
	No, I do not. When abortion for women was first put forward the reason given was that backstreet abortions were harmful to women and that they could lose their lives. This measure makes each abortion a ""back street abortion"" where there is someone with powerful medication who is perhaps alone, administering these drugs themselves. This is an irresponsible government action in my view, which takes no consideration for the child or the woman.

	No it has not. Women's safety has been compromised by allowing abortions to take place without the supervision and clinical care required. Due to this lack of supervision some have been prescribed pill well outside the recommended gestational limit, with someone reportedly aborting her baby at 28 weeks. During this time of a pandemic, services required to properly support someone through this medical procedure, which can have very serious medical and phycological affects, has been sorely lacking.
	Safety No. SPUC is very concerned about the safety of women and girls being sent abortion drugs in the post. Our concerns include: • Women taking the pills past the 10-week limit. There have been reports of women in England taking abortion pills past the 10-week limit including some past the legal 24-week limit. The consequences for women taking the pills at the wrong gestation (either through misjudging their pregnancy dates or because of deception) can be severe. In one UK study more than 50 per cent of women having medical abortions after 13 weeks needed subsequent surgical intervention (https://www.rcog.org.uk/globalassets/ documents/guidelines/abortion-guideline_web_1.pdf). • Women having to deal with complications alone at home. BPAS has claimed that abortion at home is actually safer. They point to official data published by the Department of Health and Social Care, which states that in the months April to June 2020, there were 23,061 telemedicine-enabled abortions at home in which women self-administered both mifepristone and misoprostol. It reports just one complication; a case of haemorrhage. This represents a case rate for complications of 0.043 per 1,000 abortions. The complication rate has been at least 1.6 per 1,000 abortions for many years. It is inconceivable that home abortion is so much safer than in-clinic resulting in the complication rate dropping by a factor of 36. Instead, the data suggests that doctors are completing and submitting the HSA4 form (which usually records complications) at the same time as the abortion pills are being posted to the woman. This means complications are not being recorded on the forms. It is also clear from the results of a mystery client survey (https://percuity.blog/mystery-client-survey/) that both BPAS and Marie Stopes UK are directing their clients to self-assess for any signs of complications and if necessary, to report to their local hospital. Any complications are therefore being dealt with by hospitals, and would not show up on the DHSC statistics. This is backed up by a freedom of information request to just one hospital. Lewisham and Greenwich Hospital reports managing seven admissions from 31 March 2020 to 1 September 2020 with complications after medical termination of pregnancy. • Women being sent unsafe painkillers. BPAS, MSUK, and NUPAS include codeine phosphate tablets in the treatment packs posted to their clients. Codeine phosphate is a Class B controlled drug liable to abuse and so it is rarely prescribed alone. Prescribing it for pain relief is inappropriate and unsafe, and inconsistent with NICE guidance (https://bnf.nice.org.uk/guidance/controlled-drugs-and-drug-dependence.html). Abortion providers tell us that women calling them are often in a vulnerable emotional state; we should therefore question whether it is safe to send codeine phosphate to these women. BPAS provides 28x15mg (420mg), NUPAS 120mg, and MSUK 60mg; the maximum safe daily dosage is 240mg (https://bnf.nice.org.uk/drug/codeine-phosphate.html). Taking all 28 tablets supplied in the BPAS treatment pack at once would be a toxic dose for any of these women and would result in her presenting with bluish lips, drowsiness, chest pain, and a slow heart rate. When taken together with alcohol it would be extremely dangerous. There is a significant risk that one of these vulnerable women might intentionally use these codeine tablets for an overdose. • Vulnerable women can be forced into taking abortion pills. With the spike in domestic abuse during lockdown, many women may have been forced into ordering abortion pills. Abused women could be coerced into carrying out the abortion with only their abuser present. Such women would be unable to phone for medical help because the abuser would hear. For example, one woman in a “very controlling” relationship who told her story to the Mail Online said: “The next day I felt really sick, faint and dizzy. I’m still bleeding even now, a few weeks on. Because my partner is here and doesn’t know what I did, I’ve not been able to ring anyone for any advice.” (https://www.dailymail.co.uk/femail/article-8367467/Abortions-post-got-rushed-approval-lockdown-troubling-stories-emerging.html) • Home abortion is a painful and traumatic experience for women. Carrying out a DIY abortion at home is a painful and traumatic experience for women, who are often alone. The same woman said: ““I understood I was going to have cramps, but I didn’t realise just how bad it was going to be. Two hours after I took the tablets, I started bleeding. I didn’t look because I knew it would really upset me. About six hours later the pain was unbearable. I was lying on my bathroom floor, curled in a ball. I was sweating, my temperature was 39.8, I couldn’t move. I had diarrhoea, I was being sick, I was shivering, shaking, sweating. I thought I was going to die.” Accessibility and convenience Accessibility should not be prioritised over women’s safety, proper counselling, or regulatory oversight.
	It has had a negative impact. Despite the guidelines in place, mistakes can be made with respect to the gestational age of the pregnancy. Scans are essential to check for any possible complications and to confirm eligibility for such a procedure. Vulnerable women are particularly susceptible to being coerced by abusive partners. There is no way that the clinician interviewing the woman by phone can prove that she is alone. Furthermore, it is not possible to confirm the identity of the caller If the woman has difficulty in attending a clinic, due to financial reasons, then N.H.S. Wales should provide out of pocket expenses. The care of the woman should be paramount.

	I'm very concerned about women's safety and well-being as a result of the temporary approval. I'm concerned over reports of serious failures with the home abortion scheme. Abortion providers have prescribed pills for women well outside the recommended gestational limit. I've been informed one woman was found to have aborted her baby at 28 weeks, prompting a police investigation. I am also aware (and very concerned about) that an email leaked from a regional chief midwife in England exposed the “escalating risks” of home abortion, and the serious medical complications as a result of self-administering abortion pills, including haemorrhage and sepsis.
	Wherever abortions are carried out there can be complications such as haemorrhaging and infections. It is far safer for a women if she is with easy reach of medical assistance rather than at home ,and possibly alone. A home Abortion can leave vulnerable women emotionally distressed ,and at risk of mental health problems.there have been reports of serious failures with home Abortion schemes, prescribed pills for a women was taken well out side the recommended time off 28 weeks prompting a police investigation. Women’s safety should not be compromised by allowing Abortion at home without supervision and clinical care provided by a hospital.
	Medical practitioners strongly discourage self-diagnosis, self-medication, or (perish the thought) DIY operations. My dentist would be horrified if I attempted to remove my own teeth. Yet in this area of such profound impact and consequence, not to mention risk, it is felt adequate to leave the decisions and execution in the hands of unqualified and often vulnerable people. It beggars belief!
	No... any abortion, other than the saving of the life of the mother ,has a very serious and damaging effect on many women, as well as taking of an innocent life ,and all because the little one is “unwanted”.....when many women , unable to conceive, would give him/her a life of meaning and happiness. Therefore, this heinous act must be outlawed.
	NO I believe that safety has been compromised hugely, for the sake of convenience. An abortion should only ever be conducted in a clinical setting where the mother has access to medical care.
	With regard to safety, the temporary approval has had a negative impact. The removal of the requirement for a face-to-face consultation means that: 1. Providers cannot confirm the eligibility of a woman for early medical abortion at home. This has been clearly confirmed with a Mystery Client Investigation sponsored by Christian Concern which found that in all cases women were able to obtain the pills by providing false information. https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Abortion-At-Home-A-Mystery-Client-Investigation-201210.pdf There is also evidence from a leaked email and from press reports that women have taken these pills well beyond the gestational limit of 10 weeks, with significant safety risks as a result. https://christianconcern.com/ccpressreleases/nhs-email-leak-reveals-diy-abortions-killing-and-harming-pregnant-women/ https://www.thesun.co.uk/news/11690506/police-probe-death-of-unborn-baby-after-woman-has-illegal-abortion-by-post-at-28-weeks-four-weeks-past-limit/ 2. Providers cannot confirm that it would be safe for the woman to have early medical abortion. Providers are unable to carry out a scan with telemedicine. A scan could reveal issues with the pregnancy which mean that the pills would be unsafe to take. A leaked email revealed that the Care Quality Commission were aware of 13 serious incidents relating to home abortions as of 21 May 2020. https://christianconcern.com/ccpressreleases/nhs-email-leak-reveals-diy-abortions-killing-and-harming-pregnant-women/ These included ruptured ectopics, major resuscitation for major haemorrhage, and delivery of infants up to 30 weeks gestation. Three police investigations were linked to these incidents. In October last year, the Department of Health and Social Care revealed that it had been notified of 52 women who had been prescribed the abortion pills even though their gestational age was beyond the 10-week legal limit. https://christianconcern.com/news/department-of-health-reveals-52-illegal-abortions-at-home/ 3. Providers cannot confirm the identity of the woman requesting abortion pills. This has been demonstrated with the Mystery Client Investigation which Christian Concern sponsored which found that all clients were able to obtain pills using false identities. https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Abortion-At-Home-A-Mystery-Client-Investigation-201210.pdf This means that the pills could be obtained for another person and that another woman could be pressured or forced or deceived into taking them with significant safety concerns. 4. Providers are unable to check that the woman is not being coerced. There is not a safe private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure. Evidence from Freedom of Information Requests summarised in a report published by Christian Concern shows: https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Briefings-Report-Hospital-Treatments-Complications-DIY-Abortion-210215.pdf 1. Every month some 495 women attend hospital with complications arising from abortion pills failing to complete the abortion. 250 of these women require hospital treatment to surgically remove retained products of conception. 2. 36 women make 999 calls every month seeking medical assistance for complications arising from taking abortion pills. Emergency calls relating to this were 54% higher in 2020 than in 2019. Ambulance responses were 19% higher than in 2019, even though ambulance responses in general were down 25% due to lockdowns. 3. The Care Quality Commission investigated 29 serious incidents where women accessing early medical abortion had suffered complications. 17 of these women had used the pills-by-post process. 4. The Care Quality Commission is investigating 11 cases where complications arose after abortion pills-by-post were taken when the gestational age was beyond the legal limit of 9-weeks-6-days.

	This shows that there are serious safety issues with allowing pills-by-post abortion. With regard to accessibility and convenience, the temporary approval has had a negative impact. Telemedicine may be cheaper and quicker than an in-person appointment, but the aim of medical care is not merely to adopt the cheapest or quickest approach. The Mystery Client Investigation which Christian Concern sponsored demonstrates that a telemedicine system is wide open to abuse and deception. Accessibility and convenience come at the severe price of not providing proper care and attention. Where complications arise, the accessibility or convenience may well be a subject of regret. The same applies to abuses of the system and the fact that such a system increases the accessibility and convenience of abortion pills to abusers. Where cost is a barrier to attending the clinic in person, we recommend that financial assistance should be provided by the NHS to enable an in-person consultation.
	Provision of abortion services has been compromised and so provision of good clinical services has been reduced. Not seeing women allows for - mistakes in gestation as women may have variable cycle or recall of periods - no scan allows for possibilty of ectopic and bleeding which may endanger women - no face to face assessment of womens distress or mental state examination allows more chance of women hiding their uncertainties on the phone - no face to face examination allows for coercion from others forcing women to seek abortion against their will or even to obtain tablets to pass on to others
	No a negative impact. There has been evidence of abuse of the system by women receiving pills beyond the 10 week limit, as there is no way of checking the information being given at the initial request by the woman. Women are being put in a position dangerous to their physical and mental health with no face-to-face consultation before a decision is made to carry out an abortion, no time to talk through and carefully consider the implications of their decision and no after care available to them. The whole process could leave a woman traumatised with nowhere to turn to for help.
	There have been reports of serious failures with the home abortion scheme. Pills have been prescribed by abortion providers when women have been well outside the recommended gestational limit. Mail Online reported on 23 May 2020 that a woman had an abortion at 28 weeks, prompting a police inquiry.
	Safety can only be assured if the provision can be effectively regulated by trained medical people. There are examples in England where police have investigated deaths of a full term baby and a baby at 28 weeks after their mothers got abortion pills through the post. Mystery shoppers have shown that abortion providers are sending out pills without proper checks. Not only is this criminal but it puts women at risk. The plight of women in abusive and/or coercive relationships is made worse by the new provision. Women in such situations will have been forced to order and take abortion pills against their wishes because the safety net of seeing a trained medical person is not there. Can you imaging how traumatic it must be like to be forced to have an abortion against your wishes. The provision provides an ‘excuse’ for some men to force women to have sex without any form of contraception because they can simply get abortion pills through the post if there is a pregnancy.
	No i do not think it has had a positive effect. I am concerned with the safety of these measures . There is a very real possibility that these medications can be taken outside of the approved gestation period which can lead to complications both physical and psychological.
	No, it has had an adverse effect with regards to safety.
	Yes, negative impact. DIY abortion at home is painful and traumatic. Women may take the abortion pills past the 10 week limit (even past 24 week) ; there have been cases in the media about this Kevin Duffy conducted a mystery client investigation: Volunteers posed as pregnant women seeking abortion. They acted out different roles to assess safety and compliance with the regulations. 26 out of 26 were able to get abortion pills by post, which showed that they cannot identify women or properly assess them or know that they are safe, under the legal limit, being coerced ... or even that they are the pregnant woman. eg caller posed as mother of pregnant daughter, said that she was the pregnant one and got the pills. Provider asks for first day of last period to assess how far gone. Woman gave a date in first call and then changed date in second call because first date was too long ago. In 4/4 cases the provider accepted this change. NHS email sent by senior midwife raised significant concerns about pills by post process including 13 instances of abuse, including 3 that are now ongoing police investigations. BPAS was investigating 8 cases where pills provided beyond 10 weeks. In first 6 months 52 women had received pills at home beyond the 10 week limit. These are the reported cases ... how many more are there that are not known? Vulnerable women can be forced into taking abortion pills. Providers cannot confirm the identity of the woman requesting abortion pills.
	No definitely not! I have cancelled women with post abortion traumatic symptoms .
	No. In such a life changing (and life destroying) matter, easy access, shortened waiting times and convenience trivialise what should be a most serious decision. Women, fearful and stressed, are often rushed into a decision which they may later bitterly regret. An alarmingly high percentage of women experience severe medical complications and significant psychological

	and emotional distress when aborting their child at home, where they are often alone in the shower or the toilet. Any safeguards that might exist are totally inadequate. Women are able to obtain pills on the phone by providing false information. They may be subject to coercion. Their identities cannot be properly checked.
	Home abortion often leaves women with little or no support. There is a high risk of mental health issues.
	No. A medical procedure without professional supervision is dangerous to health.
	It has a negative impact. There have been cases where women have taken abortion pills after the 10week limit; women have been coerced into taking pills and there is no safe place for women to talk freely about whether she really wants abortion or is doing so under pressure.
	The temporary approval has, i believe, in many cases had a negative impact with regard to safety because it is impossible for the health service to monitor conditions in which the abortion pills are being taken by women. The pills can be taken at any stage of the gestational term - even as late as 28 weeks and more according to media reports - without any medical supervision and well past the legal limit. Accessibility to abortion pills further increases the the danger to vulnerable women and under age girls who could be subjected to a succession of abortions without any third party intervention i.e. medical or social service.
	I do not think that the current approval of the Early Medical Abortion (EMA) is safe- it is not possible to ensure than women will not take the pills beyond the legal limit of 9 weeks 6 days gestation (even if the pills are send before that deadline). This could lead to unregulated use. Moreover, if the woman has been abused (and coerced into abortion) this might not be disclosed via a telephone or video consultation and these women would be denied the help they need. It has been reported that during lockdown the rates of domestic abuse have increased, hence this is a major concern. Coercion is much more difficult to detect via telephone or video consultation compared to face-to-face appointment.
	Abusive partners, family members or even worse sex traffickers can force vulnerable women into taking these pills at home, or any other place, against their will. The risks are great as precise time intervals are crucial. When taken at the wrong gestation time, the pills cause more pain and trauma to the woman and add to her unborn child's sufferings. It's a known fact that foetus feel pain at 12 weeks gestation. These two pills, MIFEPRISONE AND MISOPROSTOL are, I believe, carcinogenic class 1 drugs and should be treated as dangerous drugs with possible life threatening consequences to the mother and, should the attempted abortion fail to take effect, the birth of a live baby boy or girl with life long health problems.
	It has had a negative impact. Home abortion is a painful and traumatic experience for women. Women may take the abortion pills past the 10-week limit – the abortion provider cannot correctly assess how far along the woman is in her pregnancy without the usual scans. Pills by post requires the woman to be accurate in her recall of the first day of her last period in order to assess gestational age, and puts that responsibility squarely on the pregnant woman. Vulnerable women can be forced into taking abortion pills. Providers are unable to check that woman is not being coerced. There is not a safe private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure. Providers cannot confirm the identity of the woman requesting abortion pills – in our mystery client investigation, in 26 cases out of 26, our team was able to obtain the abortion pills by post, even though they provided false information and were not pregnant. In a leaked email sent by a senior midwife at the NHS, a number of concerns were highlighted, including 13 related incidents including the delivery of a baby at 30 weeks gestation, 3 police investigations, one of which is a murder investigation as there is a concern that the baby was liveborn. The Department of Health and Social Care revealed it had been notified of 52 women who had been prescribed the pills for abortion at home in the first six months of the policy, where gestational age was beyond the 10-week limit. Where cost is a barrier to attending the clinic in person, we recommend that financial assistance should be provided by the NHS to enable an in-person consultation.
	Safety: -women's safety should not be compromised by allowing minimal, if any, professional involvement. - there have been reports of serious failures with the scheme at present in place [use at much later than the permitted 10 weeks; known complications which can be life-threatening if medical services are not quickly available.] - a regional Chief Midwife has mentioned the "escalating risks " of home abortion. Accessibility- just as the accessibility of abortion itself has increased the damaging consequences, so will the 'freedom' which this ease of access allow. - because of this ease, vulnerable women will have less support for the immediate medical and long-term psychological consequences of this relaxation. [women who have had an abortion experience a 81% higher risk of mental health compared with those who have not had an abortion]
	I do not have enough information to answer this question and there has not been enough time to answer it properly. How do you define positive impacts of a service that is fundamentally negative. Wherever an abortion occurs it will result in many people in pain possibly physical and mental and there will be no change in that whether it occurs at home or in hospital. No it will not be safe if there is haemorraging or sepsis. Yes it probably is accessible and convenient but that really should not be the aim when we are talking about the ending of a human life. The study below shows that 1 in 5 mothers suffered complications after a medical abortion. 1. Niinimäki, M, Pouta, A, Bloigu, A et al, 'Immediate Complications After Medical Compared With Surgical Termination of Pregnancy', Obstetrics and Gynaecology, 114(4), October 2009, pages 795-804

	More convenient access to abortion increases the number of aborted unborn children. Convenience is not always right.
	Safety is compromised by allowing abortions to take place in an unsupervised clinical environment .Any abortion carries a risk of complications ,such as haemorrhaging, infection and sepsis . It is safer for women to have access to medical help rather being on their own at home . There have been reports of serious complications with home abortions by self administering abortion pills , with one woman aborting a 28 week pregnancy - there maybe others that we do not know about . I fear, women who are desperate to end a pregnancy will not adhere to the medical guidelines for this medication with the possibility of dire consequences . Home abortion leaves the woman with no support or follow up .
	I imagine that it has had a positive effect in terms of accessibility and convenience, but am concerned that it may well have had a negative effect with regard to safety. During the pandemic, when we are being urged to stay at home as much as possible, it is obviously more convenient to have a telephone consultation rather than a face to face one. However, it is possible that the telephone consultation may miss non-verbal cues or that the caller may be being coerced in a way that would not be possible in a private face to face meeting.
	I am very concerned that this temporary approval could negatively impact vulnerable women. Surely close medical supervision and support is required in order that women remain safe both physically and mentally.
	With regard to women's safety, it has had a negative impact. Women have not received the proper medical supervision and clinical care which they need and which they would have received if they had been able to attend an appointment with a doctor. Abortion carries the potential risk of dangerous complications and it is not safe for women to run the risk of having to face these when alone at home. The same is true of the mental health damage that is the consequence of the emotional trauma of abortion. Moreover, it is known that abortion providers have in many cases prescribed the pills to women who are beyond the 10-week limit of gestation.
	I think this temporary approval is most unsafe for all women , it has already been noted that women have received the pills through the post when they are well past the legal limit even up to 28 weeks gestation.
	Overall no. While the temporary approval has made abortion more convenient for abortion providers and also possibly more convenient for some women seeking abortion by medical means, it has certainly had a detrimental impact on the safety for women. The decision for any woman to choose abortion over continuing her pregnancy is very often difficult, emotive and complex. Sometimes women are under tremendous emotional or other pressures, often from others, to undergo abortion when they are really not sure if that is what they really want to do. The lack of face to face consultations is entirely insufficient to help women in these difficult situations to discuss in the detail they require the emotional and psychological impact of undergoing abortion, in addition to the potential risks to their physical health associated with the procedure. There is a particular concern that the temporary measures greatly facilitate abuse of the Abortion Act and allow abortions to be carried out illegally. This includes the very real risk of abortions being carried out on minors with the medications obtained by other persons and also a risk of surreptitious administration of the abortion-inducing medications being administered to pregnant women without their consent.
	No. Medical abortions have the potential to cause grave harm to women. Taking them in her own home with next to no medical assessment or ongoing observation is dangerous for her. It will also be very easy for someone to abuse this system. For instance, an abuser who wishes to have a pregnancy covered up. Or someone who is pressurising a woman to have an abortion against her will. Any woman could obtain these pills on behalf of someone else, unbeknown to the provider, in this way vulnerable and abused persons may never be noticed and offered help. Women can also procure the pills when they are beyond the gestational age limit that they are designed for, by accident or design. Again we see the potential for grave harm to the women's health, not to mention what suffering a baby would go through. I am sure it is highly convenient for a woman to obtain abortion pills without having to leave home - but at what price? And is an abortion something that should be so convenient, when you consider the physical and long term mental health issues that some women suffer?
	Project Truth is a public information initiative. Since 2013 we have been setting up pro-life information stalls in various towns and cities around Scotland to discuss the topic of abortion with the public. We offer information pertaining to foetal development and speak to many people who have faced/are facing challenging situations involving pregnancy or who have had abortions. From our experience with speaking to countless women who have had abortions, we know that abortion can be a painful and traumatic experience, even without the added pressure of carrying out a medical abortion at home - most likely alone. We do not believe that temporary approval of medical termination at home has had a positive impact. There are several risks associated with home abortions: • Medical abortions should not happen at home past 10 weeks gestation. But, without an in-person appointment, there is no way to ensure that women are not requesting these pills and having medical abortions at a later gestation. There have been reports over lockdown of women in England taking abortion pills past the 10-week limit, including some past the legal 24- week limit. We cannot ignore that this might be happening or will happen in Wales. • There is little to stop vulnerable women from being forced into taking abortion pills by abusive partners or family members. There has been a significant spike in domestic abuse during lockdown. Without an in-person appointment, there are fewer opportunities for a doctor to identify potential abuse. Additionally, technology (phones and computers) are often controlled by perpetrators of domestic abuse. With consultations happening

	over the phone, it is not possible to protect women from aspects of this control and reproductive coercion. Women may be coerced by partners and family members to have abortions that they do not want.
	No. I am very concerned that this has opened a can of worms which can be detrimental to women's safety: the lack of a scan to confirm the date can lead to a later abortion with much greater risk; the inability of a telephone consultation to ensure that no coercion is involved, or even if the woman applying is the one who will be taking the drugs; even robust women can be shaken by the reality of abortion, how much greater the additional risk to a vulnerable woman trying to cope alone, particularly if there are medical complications?
	No, it has had a negative impact It is simply not possible for service providers when solely using telemedicine to be certain of a woman's eligibility or suitability for early medical abortion at home. They are relying on the woman's accurate, complete, and honest declaration about her current state of health, her medical history, and the gestational age of her pregnancy, based on her recall of LMP. Women might not always get this right, or they may deliberately mislead the provider. This is important because the potential harm of side-effects or adverse events increases with gestation and are more critical if an ectopic is missed. In the mystery client investigation which I led, we recorded 26 cases out of 26 in which women were able to obtain the abortion pills for use at home, whilst providing incomplete and inaccurate information, especially related to the date of their LMP. The DHSC, in response to a freedom of information request FOI-1250644, released data reporting 52 cases in England and Wales in which the gestational age was beyond the prescribed 10 week limit for abortion at home. An NHS email on May 21, indicated concerns about the escalating risk around the pills-by-post process, noting that the CQC was at that time aware of 13 incidents arising from this process. The writer of the email notes that this is a small number of incidents but each with tragic, poor outcomes for women. They also note that these are just those incidents which the sector deems 'significant', requiring reporting to the regulator, and that many other adverse outcomes are seen to be 'normal' complications of medical abortion. https://www.gov.uk/government/statistics/abortion-statistics-during-the-coronavirus-pandemic-january-to-june-2020 http://percuity.blog/nhs-email/ BPAS shows on its website the increasing incidence of side-effects and adverse events, when comparing <9 weeks and the tenth week. The rate of incomplete abortion rises from 3% to 7% in just that one week, and medical guidelines show that it continues to increase with increasing GA. The clinic visits which were a routine integral part of the abortion care pathway before the March 30 approval, included a professional clinical assessment of eligibility and the use of ultrasound scan to confirm the gestational age. https://www.bpas.org/abortion-care/abortion-treatments/the-abortion-pill/abortion-pill-up-to-10-weeks/ In our investigation we conducted cases with each of BPAS and MSUK in which the woman's coercive partner was sitting beside her during her calls. When asked by the provider if she is safe and on her own, she answered yes. During these calls, the coercive partner can be seen prompting the woman to give particular answers to critical questions. When solely relying on phone calls, abortion service providers are simply not able to detect if their client is safe and alone, or actively being coerced. These particularly vulnerable, at risk, women need the privacy of a safe counselling space in which a trained professional can take time to provide client-centred care. http://percuity.blog/mystery-client-survey/ The investigation completed five cases in which the woman making the calls was not pregnant and was phoning to obtain the abortion pills to be administered to another person. The persona we used was a non-pregnant mother calling to get the pills for her pregnant adolescent daughter, who she wanted to keep out of the 'system'. In the real world, outside of the investigation, it is impossible for service providers solely relying on phone calls, to know who the abortion pills will be administered to. Whereas when an in-clinic consultation is mandated, the service provider is able to confirm the client's eligibility for EMA and be certain that it is the woman present that the prescribed pills will be administered to. Prior to the March 30 approval, it would have been fair to say that early medical abortion can be a safe and effective method of abortion, even when the expulsion occurs at home, in large part because of the routine in-clinic consultation and assessment. When relying solely on remote telemedicine consultations, this is no longer the case, this approval has had a negative impact on women's safety. It would be fair to note that the inclusion of telemedicine can improve the accessibility and convenience of services, but telemedicine should not be the whole of the process. There is no doubt that the inclusion of telemedicine into the overall abortion care process can help to reduce time delays and costs, for both the service provider organisation and its clients. Telemedicine is appropriate for the initial contact between a woman and her chosen service provider, and for follow-up post-procedure. However, telemedicine alone is not sufficient to ensure a safe and accurate assessment of a woman's eligibility for an early medical abortion at home. The 2019 NICE guideline 'Abortion Care' is often cited as recommending the use of telemedicine for abortion

	assessments, but this is far from definitive. Indeed, the recommendation to consider providing abortion assessments by phone is in the context of making it easier and quicker for women to access this service. The implied context in this guideline is that phone calls should be considered as part of the process, rather than becoming the whole of the process. It is worth noting that this same guideline also recommends that abortion can be provided without first needing to use an ultrasound scan to definitively confirm the pregnancy. This has been cited as rationale by RCOG for the no-test protocol in its updated guideline for early medical abortion care management during the COVID-19 pandemic. However, the context for this NICE recommendation is that organisations providing a surgical abortion without prior ultrasound scan will need to have staff trained to inspect the products of conception for the presence of chorionic villi and a gestational sac. When providing medical abortion without prior ultrasound scan, the organisation must be able to assess serum human chorionic gonadotrophin (hCG) and have staff trained in interpreting test results. This implies that the NICE no-ultrasound protocol is in the context of an overall abortion procedure which includes some clinic-based processes. This NICE guideline predates the March 2020 change in which abortion-at-home was approved. It was written prior to there being government approval for the abortion procedure to be completed on a fully remote basis. When considering a fully-remote procedure, it is unsafe to rely upon recommendations made for an abortion procedure which included some in-clinic processes and some remote by phone. We should not adapt these recommendations from a hybrid-location to a fully-remote basis, without first completing a comprehensive safety review based on primary research. We acknowledge that some women live at distance from their nearest abortion clinic and do not have easy or affordable access to transport. Our recommendation is that rather than relying solely on telemedicine, it would be safer and more effective to provide financial assistance to those women who need it, to cover their out-of-pocket expenses for travel, time away from paid employment, childcare costs, and any necessary overnight stays. This is already a proven process for women living in Northern Ireland who have to travel to England to access services.
	I think home abortion is a painful and traumatic experience for women so has had a negative impact. Also - the provider can't tell how far along a woman is and if over the 10 week limit
	No, It has had a negative impact. Home abortion is a painful and traumatic experience for women. Women may take the abortion pills past the 10-week limit – the abortion provider cannot correctly assess how far along the woman is in her pregnancy without the usual scans. Pills by post requires the woman to be accurate in her recall of the first day of her last period in order to assess gestational age, and puts that responsibility squarely on the pregnant woman. Vulnerable women can be forced into taking abortion pills. Providers are unable to check that woman is not being coerced. There is not a safe private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure. Also providers cannot confirm the identity of the woman requesting abortion pills. We live in an era where anyone can assume another identity remotely and lie. How can a electronic consultation or a telephone give accurate information?. It will only increase quick decision making and continue to add to the trauma and suffering for the women involved and ultimately their health.
	The impact has without a doubt been positive. Evidence from many studies has long highlight the safety, effectiveness, and acceptability of early medical abortion provided by telemedicine (Endler et al. 2019). More recently - and specifically in relation to the new services offered in the United Kingdom since the approval order was issued - this evidence has been strengthened (Aiken et al. 2021). In particular, it has been shown that the average gestational age when a pregnant person accesses abortion services by telemedicine is lower, which is preferable both in terms of reduced health risks and individual wellbeing. Concerns raised by those opposed to the change are unfounded. Organisations such as Christian Concern - which are entirely opposed to abortion so would never have taken an honest look at the data on telemedical provision - have suggested that it will not be possible to confirm gestational ages, nor will effective safeguarding be feasible. First, we know that dating a pregnancy based on the person's last menstrual period is highly accurate. Second, the British Pregnancy Advisory Service's data thus far has shown an increase in safeguarding referrals (2020) - quite clearly, they are not sitting back and letting patients in difficult situations pass them by. Ultimately, the evidence is overwhelmingly in favour of the provision of early medical abortion by telemedicine, enabling patients to see through the procedure in the comfort of their own homes. This change should have been introduced long ago, and there is a clear moral imperative to do so in light of the evidence (Parsons 2021). A decision to allow the temporary approval to expire would suggest that the Welsh Government does not believe in evidence-based policy or medical research. Aiken A, Lohr PA, Lord J, Ghosh N, Starling J. Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study. BJOG 2021: 10.1111/1471-0528.16668. British Pregnancy Advisory Service (2020) Pills by Post: Telemedical Abortion at the British Pregnancy Advisory Service (BPAS). Available at: https://www.bpas.org/media/3385/bpas-pills-by-post-service.pdf Endler M, Lavelanet A, Cleeve A, Ganatra B, Gomperts R, Gemzell-Danielsson K. Telemedicine for medical abortion: a systematic review. BJOG 2019;126:1094-1102.

	Parsons JA. The telemedical imperative. Bioethics 2021: 10.1111/bioe.12847.
	Vulnerable women can be forced into taking abortion pills. Providers are unable to check that woman is not being coerced. There is not a safe private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure.
	No emotional or psychological exploration of impact of abortion after it has happened
	I consider that the temporary approval has had a negative impact on the provision of abortion services, because womens wellbeing is being endangered. These are powerful drugs which should only be taken under medical supervision. The problems arising when taking them are being picked up by our NHS which is already struggling due to covid 19 not the abortion providers who just hand them out willy nilly. A generation of women are going to be damaged by this reckless policy if it continues.
	I am concerned about such important consultations continuing in the future without direct face-to-face contact with the Family Doctor.
	I consider that the temporary approval has had a negative impact on the provision of abortion services for women, particularly with regard to safety. Women should not have to go through the traumatic experience of abortion unsupervised and without expert emergency back up if common complications arise. A regional chief midwife in England spoke of the ""escalating risks"" of home abortion, and the serious medical complications that may arise as a result of self-administering abortion pills, including haemorrhage and sepsis. Women should also have access to emotional support. Women who have had an abortion experience an 81% higher risk of mental health problems when compared with women who had not had an abortion. Obviously the fact that she may be alone when carrying out the abortion, not to mention the traumatic process of expelling and disposing of the unborn baby adds hugely to her mental stress. Also there have been reports of providers prescribing pills for women well outside the recommended gestational limit; one women was found to have aborted her baby at 28 weeks (prompting a police investigation).
	No. It ha a negative effect on the safety of women There is no real provision of support for women to help them make their decision. Because the only person they speak to on the phone can easily be give false information by the caller who may not be the woman anyway. There have also been cases where20 weeks have been sent the pills , even up to 28 weeks , and BPAS have been doing this. The side effects of post parted hem orange can be traumatic for the woman and may be untreated for a length of time that could be detrimental to the patient. The sight of a 3-4 inch foetus suddenly discharged would be very distressing and could lead to complex mental health issues. There is no guarantee that the woman will take the pills immediately and that c old run Ito other problems of safeguarding and entering an illegal time slot.
	No, there are extreme safety issues for women and girls with the remote DIY home abortion provision. I feel the temporary approval of DIY abortion to be extremely dangerous to the woman's safety, both physically and psychologically. There is a difficulty in regulating them. The abortion drugs are sent through the post, without the woman having a face to face discussion with a doctor or any counselling. There is a danger of the abortion drugs being taken at the "wrong gestation". In England, an expectant mother of 28 weeks gestation had taken the two abortion drugs that were sent in the post. Women are more susceptible to being coerced into an abortion by an abusive partner or family member. The DIY abortion process is not a straightforward process. And yet a woman has to take two powerful abortion drugs; one which kills the unborn baby and has to leave at least 24 hours in between taking the second drug that expels the unborn baby. This horrific, dangerous ordeal is performed alone and away from any medical care or setting. Women are being sent abortion drugs without any proper checks; A mystery shopping exercise has exposed this practice, putting them at risk.
	No. There are serious safety concerns. Firstly, there is no way that the provider can be sure that a woman who requests an abortion by post is doing so freely and not under duress or coercion, in fact, they cannot even be sure of the true identity of the woman requesting the pills. Secondly, abortion pills can be used by women who are over the 10 week limit. Thirdly, home abortion is a painful, traumatic and dangerous process, which women undergo without medical supervision. Finally, if costs are regarded as a barrier for attending a clinic, then financial support should be provided to allow for these safety concerns to be addressed. Women need a system fit for purpose, not one which has no checks and balances for safety concerns.
	Abortion whether DIY un supervived medically is highly dangerous to the woman and her un-born child. Wemon will be put under even more pressure to terminate their pregnancy at home without counselling or medical advice. This is not women's Health Care. It's is a complete abandonment of the protection and health of the woman and her baby.
	I do NOT consider this approval has had a positive impact on the provision of abortion services for women. All abortions carry substantial risks to the mother and therefore any abortion carried out without proper medical supervision is utterly irresponsible. There is no way posting tablets to women to carry out DIY abortions can be done safety. How can you ensure the tablets go to the correct woman or who will use them or at what stage they will be used. Safety is the priority here. Accessibility and convenience of service should not even be considered if it is not safe.
	It has had a negative impact. Home abortion is a painful and traumatic experience for women. Women may take the abortion pills past the 10-week limit – the abortion provider cannot correctly assess how far along the woman is in her pregnancy without the usual scans. Pills by post requires the woman to be accurate in her recall of the first day of her last period in order to assess gestational age, and puts that responsibility squarely

	on the pregnant woman. Vulnerable women can be forced into taking abortion pills. Providers are unable to check that woman is not being coerced. There is not a safe private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure. Providers cannot confirm the identity of the woman requesting abortion pills – in our mystery client investigation, in 26 cases out of 26, our team was able to obtain the abortion pills by post, even though they provided false information and were not pregnant. In a leaked email sent by a senior midwife at the NHS, a number of concerns were highlighted, including 13 related incidents including the delivery of a baby at 30 weeks gestation, 3 police investigations, one of which is a murder investigation as there is a concern that the baby was liveborn. The Department of Health and Social Care revealed it had been notified of 52 women who had been prescribed the pills for abortion at home in the first six months of the policy, where gestational age was beyond the 10-week limit. Where cost is a barrier to attending the clinic in person, we recommend that financial assistance should be provided by the NHS to enable an in-person consultation.
	No, I do not. Remote abortion providers have no way of determining the stage the pregnancy has reached. Most women seeking pills will have already decided an abortion is for them and so their word on this matter should never be trusted without further corroboration. Additionally, some women will be under coercion from a parent or abusive partner to dispose of the inconvenient baby. In a recent investigation all 26 women giving false information and not pregnant were able to obtain pills.
	No, I do not. Home abortions compromise the safety of women using the procedure. There is no medical supervision and complications can arise, needing medical intervention e.g. haemorrhaging and sepsis. There have been serious failures with the home abortion scheme, with providers prescribing pills to for women well outside the 10-week limit. Home abortion can leave vulnerable women with little support, perticularly in dealing with the post-abortion mental health issues.
	It has had a negative impact. Women may now experience the pain and trauma of an abortion at home - and it is a painful and traumatic experience, whether or not the abortion was the woman's choice. However, vulnerable women can be forced or coerced into taking the pills and providers are unable to check whether this is really taking place. Although women may be asked on the phone, there is no way to ensure that the woman is in a private, safe space and able to talk freely unless she is in the clinic with the clinician. A phone consultation is not good enough to ensure that the woman really wants to go ahead with the abortion. There have been multiple stories of women not being properly checked before being sent the pills and then suffering the harmful consequences of either an unwanted abortion, or complications that could have been avoided if the woman had been seen in-clinic. There is also no way to assess gestational age properly, and sole responsibility of assessing how far along in the pregnancy the woman is rests with the woman herself. This means pills can easily be taken past the 10-week limit if the woman either isn't sure of gestational age or lies about gestational age. The Department of Health and Social Care revealed it had been notified of 52 women who had been prescribed the pills for abortion at home in the first six months of the policy, where gestational age was beyond the 10-week limit.
	No it has been negative. Medical abortions at home have led to serious complications. There is also a risk of coercion and domesic abuse, which cannot be verified. some people ma wrongly report the stage of their pregnancy, which again cannot be verified. the risk of complications increases as the stages progress. Accessibility and convenience are not the only criteria, and are less important than women's health and well being. Remote provision of services increased the risk of abuse as there is no way of verifying the person's situation
	No. There is no way to check whether the woman is being coerced. There is also no way to check whether she is mistaken about the gestational age of the fetus, which could lead to serious complications.
	Allowing women to take abortion pills at home has had a negative impact on safety. Women’s care should not be compromised by allowing abortions to take place without the supervision and clinical care equivalent to that provided by a hospital. There have already been reports of serious failures with the home abortion scheme in other parts of the UK. Abortion providers have prescribed pills for women well outside the recommended gestational limit. One woman was found to have aborted her baby at 28 weeks, prompting a police investigation.[1] An email leaked from a regional chief midwife in England exposed the “escalating risks” of home abortion, and the serious medical complications as a result of self-administering abortion pills, including haemorrhage and sepsis.[2] Home abortion can leave vulnerable women with little support. Studies have repeatedly shown that women experience emotional distress after an abortion. According to one study women who have had an abortion experience an 81 per cent higher risk of mental health problems when compared with women who have not had an abortion. [3] This is amplified by the fact that they could be alone when carrying out the abortion, not to mention the traumatic process of expelling and disposing of the unborn baby. The lack of medical supervision for the administration of these powerful drugs exacerbates all the risks. In medical

	abortions, the timing between taking the two pills (mifepristone and misoprostol) is crucial. Taking the pills incorrectly significantly increases the risk of complications. One large study found that a fifth of women who had medical abortions suffered complications.[4] It is far better for a woman to be within easy reach of medical assistance. Advocates for abortion often say that allowing women to take abortion pills at home will 'protect women'. But enabling women to take medication strong enough to kill and expel an unborn baby from the womb at home, potentially by themselves, is not safe. [1] Mail Online, 23 May 2020, see https://www.dailymail.co.uk/news/ article-8349739/Police-investigate-death-unborn-baby-woman-took-abortiondrugs-home-28-weeks-pregnant.html as at 17 December 2020 [2] Email dated 21 May 2020, see https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Misc-Judicial-Review-Abortion-200729-NHS-email-2.pdf as at 17 December 2020 [3] Coleman, P K, 'Abortion and mental health: quantitative synthesis and analysis of research published 1995-2009, British Journal of Psychiatry, 199(3), 2011, pages 180-186 [4] Niinimäki, M, Pouta, A, Bloigu, A et al, 'Immediate Complications After Medical Compared With Surgical Termination of Pregnancy', Obstetrics and Gynaecology, 114(4), October 2009, pages 795-804
	No. Safety has been compromised (see answer to Q3 below) including protection from coercion to abort. There is a real doubt whether the medical risks can be adequately explored in a brief remote consultation, and if it is right in any case to impose these risks, especially for a social indication, bearing in mind that pregnancy is not itself a disease. Medical abortion can cause harms including fatalities in connection with haemorrhage, sepsis and ruptured ectopics; moreover, home abortion will exacerbate the risks. The 2020 Cochrane Systematic Review www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD013181.pub2/abstract states that "Data are limited by the scarcity of high quality research study designs and the presence of risks of bias", concluding that "it remains unclear whether self administration of medical abortion is effective and safe." The question also assumes that convenience and accessibility are good things, but speedy access to a life-changing procedure for the woman is not an obvious good or indeed a good at all. We would not suggest of similarly momentous life choices such as relinquishing a baby for adoption that they should be actioned instantaneously and neither should we suggest this of abortion. Some women who deeply regret their abortions object precisely to the speed with which they were offered them, leaving little time to seek and find counselling independent of the abortion provider or positive help, practical or emotional, to take the pregnancy to term. It is sadly the case that abortion providers rarely signpost women to organisations, including voluntary organisations, which can provide just such counselling and help.
	I consider it has had a negative impact. Home abortion is likely to be a painful and traumatic experience for a woman. Women may take the abortion pills past the 10-week limit – how far she is along in her pregnancy cannot be accurately assessed without the usual scans. Responsibility is placed wholly on the pregnant woman.
	no, two deaths is too many. Complications without immediate intervention is an ever present danger
	Whilst we do believe that there will be greater privacy and confidentiality for the recipients of the abortion pills we do not agree this is necessarily a good thing. We expect that there will be minors who would secretly get these pills and have an abortion without anyone knowing. The problem here is that if complications arise, as they can with medical abortions, would these minors be willing to then access emergency services knowing that they are having the abortion secretly? If this occurs, it could have grave and maybe even fatal consequences. We should point out that deception is made easier by these new practices which emphasise secrecy (privacy).
	No. Safety - When considering this temporary approval, safety concerns should always be the most important factor, therefore to ensure this, focus should be given to supervision, consultation, and clinical care. These things should not be compromised to increase ease of access and convenience, something that is suggested in this question by listing all three factors alongside each other, indicating equal importance. Abortions are often a painful and traumatic experience for women. They carry the risk of causing haemorrhaging, infection, sepsis, and uterine perforation. If such complications were to arise with a home abortion, the woman would be placed in an incredibly dangerous and compromised position, with medical assistance being out of immediate reach. In an attempt to decrease the risk of such complications happening, the telemedicine advice that is given explains that the pills are to be taken up to 9 weeks and 6 days after gestation. By relying on this, the Government is greatly overestimating the woman's ability to judge their gestation period, and not considering the fact that many women have irregular cycles, do not track their periods and use contraception, thus resulting in an inaccurate date. The accuracy of the gestation period is crucial as the risk of taking pills after the 9 weeks and 6 days post-gestation, significantly increases and puts women's lives in danger. In fact, the British Pregnancy Advisory Service revealed that the need for surgical treatment to complete an abortion more than doubles when taken 9-10 weeks after gestation, compared to when the pill is taken up to 9 weeks after gestation (7 in 100 compared with 3) (Bpas.org. 2021. Medical Abortion Up to 10 Weeks | BPAS. [online] Available at: <https://www.bpas.org/abortion-care/abortion-treatments/the-abortion-pill/abortion-pill-up-to-10-weeks/> [Accessed 23 February 2021].). What is worrying also, is that the research into what the impact would be if the woman were to take the second pill at an even later date is incredibly varied and primitive, with the Christian Medical Fellowship (CMF) revealing that, "For abortions after 13 weeks gestation, the proportion of incomplete

	medical abortions needing subsequent surgical intervention varies widely between studies, from 2.5% in one study up to 53% in a UK multicentre study", and then later, stating more generally that "The RCOG (Royal College of Obstetricians and Gynaecologists) also reports that women are more likely to need medical help for bleeding after medical abortion than after surgical, to report heavier bleeding than they expected, and for longer". (Taylor, P., 2018. Medical abortion: concerns about taking a pill at home. [online] Christian Medical Fellowship - cmf.org.uk. Available at: <https://www.cmf.org.uk/resources/publications/content/?context=article&id=26785> [Accessed 23 February 2021].) And finally on safety, because home abortions remove the insight and expertise of medical professions that would normally be available through supervision, consultation and clinical care, there would be no way in knowing whether the woman had an ectopic pregnancy, something only discoverable via an ultrasound. Accessibility - Whilst this legislation makes it more accessible for women to end the life of an unborn child, it removes access to proper supervision, consultation, and clinical care, thus undermining the safety of the woman and unborn child and also the enormity of the decision to undertake the abortion. What the legislation does not consider is that abusive partners would be able to take advantage of the medical abortion's ease of access. Because the consultation for home abortions take place over the phone, and don't require an in person visit to a hospital, there is no way to monitor whether the woman having the phone call is being forced to do so by an abusive partner, thus removing any control the woman has on what is ultimately a life-altering decision. Continuing with the fact that medical abortions are more exposed to abuse and deception, providers of the home abortion pills are unable to confirm the identity of the women requesting the service. Independent public health expert Kevin Duffy investigated how the system may be misused, conducting a mystery client exercise. The findings from the exercise demonstrate that in 26 cases out of 26, the 'mystery shoppers' were able to obtain the medical abortion pills even when they gave false information, thus revealing that the home abortion service cannot confirm identity, cannot confirm clinical eligibility, or how far along the woman is with their pregnancy. In four cases, the 'mystery shopper' changed their gestation date on the second call so that they would fit with the time criteria, and all four of these cases saw their consultations moved on and processed to the next stage of the service. (Williams, A., 2020. Abortion at Home: a Mystery Client Investigation. [online] Christianconcern.com. Available at: <https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Abortion-At-Home-A-Mystery-Client-Investigation-201210.pdf> [Accessed 23 February 2021]). Convenience - It is concerning that convenience appears to be one of the primary drivers of the legislation, and whilst we do not believe it to be the intention of the Welsh Government, it ultimately undermines the human dignity of both the woman and unborn child involved. Even when sincerely held different moral positions are taken around this issue it can surely never be right to cheapen both the procedure and the lives involved by simply making services a matter of convenience. The prospect of terminating your pregnancy within 9 weeks and 6 days of gestation may also seem a convenient 'quick fix' to some women, however this narrow and constrictive window may lead to many women living with enormous regret and guilt once the medical abortion has taken place
	Home abortion can be a traumatic experience for women
	I consider the temporary approval has had a NEGATIVE impact Abortion may be considered a safe procedure with major complications rare but statistics would verify that it is not risk free. It is impossible to accurately verify gestation by telephone or video consultation and unfortunately the later the pregnancy the higher the risk of complications. a leaked email sent by a Regional Chief Midwife exposed the escalating risks of home abortion and the serious medical complications as a result of self administering abortion pills, including infection, haemorrhaging and even sepsis The lack of access to follow up care is another concern, for the physical, emotional and mental well being of the woman Complications are less likely to be recorded in a non clinical environment.
	The considerations of safety, accessibility and convenience of abortion services are indeed a critical question. However, the termination of a human being is not in the same realm as being close to a supermarket that has midnight opening hours. A trip to Tesco at 2am to satisfy the desire for pizza is not to be considered as convenient as ""getting rid"" of a growing human, with all of the potential such a life had before him/her. The inconvenience of an unexpected pregnancy should not be able to be acted upon so hastily without proper advice if the risks of the abortion procedure and other options, such as adoption, explored. An unplanned pregnancy may well bleave a woman in an emotionally confused state that warrants counselling and comfort, not a quick fix. To save NHS intervention/costs at one point does not save costs in the outcome of a woman undergoing haemorrhage and infection at home. In fact, it compounds the costs to NHS services.

	No, I think it has had a negative impact, particularly with regard to safety. In the consultation document you mention that you are aware of ""a small number of cases in England where a termination of pregnancy at home has occurred after the 9 weeks 6 days gestation limit."" A recent freedom of information (FOI) request to the English CQC (Care Quality Commission) has revealed that a case still occurred in England in November (and that one case involved a major haemorrhage) (https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Briefings-Report-Hospital-Treatments-Complications-DIY-Abortion-210215.pdf, https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Misc-FOI-DIY-Abortion-210205.pdf). If ""gestation greater than expected"" incidents were still happening in England in November despite the awareness of the issues, it seems likely that they could still happen or be happening in Wales. The same FOI request revealed that the CQC was aware of 6 ectopic pregnancy incidents including two ruptured ectopics from TOPs (terminations of pregnancy). It would seem likely that these related to the temporary approval for the ""pills by post"" scheme, as anyone who attended a clinic should have had a dating scan which would have identified the ectopic pregnancy. Again, these incidents could just as easily occur in Wales. Furthermore, the same FOI research reveals that complications are much more common than abortion providers suggest, including that ""each month across England and Wales there are an average of 20 ambulance emergency responses for complications related to medical abortion at home (https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Briefings-Report-Hospital-Treatments-Complications-DIY-Abortion-210215.pdf). A further safety risk is that of coerced abortion. A recently publicised case in England (https://youtu.be/87GZzVS7dd8) shows how this can easily happen. With telephone consultations there is no opportunity to ensure the privacy to ask a woman by herself whether she wishes to have an abortion. Also, there are many for whom a telephone or video appointment is more convenient, but some will find such methods much harder, such as those with intellectual disability, deafness, those with mental illness, or those who find technology difficult (https://publications.parliament.uk/pa/cm5801/cmselect/cmhealth/320/32009.htm).
	It has had a negative impact. Home abortion is a painful and traumatic experience for women. There's a strong risk, and likelihood that they may take the abortion pills past the 10-week limit – the abortion provider cannot correctly assess how far along the woman is in her pregnancy without the usual scans. Pills by post requires the woman to be accurate in her recall of the first day of her last period in order to assess gestational age, and puts that responsibility squarely on the pregnant woman. Vulnerable women can be forced into taking abortion pills. Providers are unable to check that woman is not being coerced. There is not a safe private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure. Providers cannot confirm the identity of the woman requesting abortion pills – in our mystery client investigation, in 26 cases out of 26, our team was able to obtain the abortion pills by post, even though they provided false information and were not pregnant. In a leaked email sent by a senior midwife at the NHS, a number of concerns were highlighted, including 13 related incidents including the delivery of a baby at 30 weeks gestation, 3 police investigations, one of which is a murder investigation as there is a concern that the baby was liveborn. The Department of Health and Social Care revealed it had been notified of 52 women who had been prescribed the pills for abortion at home in the first six months of the policy, where gestational age was beyond the 10-week limit. Where cost is a barrier to attending the clinic in person, we recommend that financial assistance should be provided by the NHS to enable an in-person consultation.
	- It has had a negative impact. - Home abortion is a painful and traumatic experience for women. - Women may take the abortion pills past the 10-week limit. The abortion provider cannot correctly assess how far along the woman is in her pregnancy without the usual scans. Pills by post requires the woman to be accurate in her recall of the first day of her last period in order to assess gestational age, and puts that responsibility squarely on the pregnant woman. - Vulnerable women can be forced into taking abortion pills. Providers are unable to check that woman is not being coerced. There is not a safe private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure. - Providers cannot confirm the identity of the woman requesting abortion pills. A mystery client investigation (by Christian Concern) found that in all 26 cases, the team were able to obtain the abortion pills by post, even though they provided false information and were not pregnant. - In a leaked email sent by a senior midwife at the NHS, a number of concerns were highlighted, including 13 related incidents including the delivery of a baby at 30 weeks gestation, 3 police investigations, one of which is a murder investigation as there is a concern that the baby was liveborn. - The Department of Health and Social Care revealed it had been notified of 52 women who had been prescribed the pills for abortion at home in the first six months of the policy, where gestational age was beyond the 10-week limit. - Where cost is a barrier to attending the clinic in person, financial assistance should be provided by the NHS to enable an in-person consultation.
	Safety has to be the main concern, it must trump accessibilty and convenience.
	A negative impact 1) Reducing abortion to a telephone call means women are receiving less support during current temporary measures due to covid-19 and so are less safe. Cases of domestic abuse, mental and physical health problems, and human trafficking in Wales could have been missed. The Office of National Statistics for England & Wales

	during the initial covid-19 period when many women undergoing abortion did not attend a clinic finds “The number of arrests for domestic abuse-related crimes between 1 April and 30 June 2020 increased by 24% compared with the same period in the previous year (from 49,534 to 61,275 in the 37 police forces that could supply adequate data for both periods). This follows a 11% increase in the number of arrests for domestic abuse-related crimes in the year ending March 2020, compared with the previous year (in the 38 police forces that supplied data in both years).” (https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2020) The accompanying bulletin states “The police recorded 259,324 offences (excluding fraud) flagged as domestic abuse-related in the period March to June 2020. This represents a 7% increase from 242,413 in the same period in 2019.” meaning the impact on women’s safety during the current temporary measures in Wales could have been significant. With the rate of abortion in Wales rising in recent years to at or near record levels at 16.1 per 1,000 women in 2019, a study of clinics in the north east of England found participants undergoing abortion were six times more likely to be the subject of physical domestic violence than women preparing to give birth at 5.8% versus 0.9% likelihood respectively and five times more likely to suffer emotional abuse at 9.9% versus 1.8% respectively (http://onlinelibrary.wiley.com/doi/10.1111/1471-0528.12609/abstract), as do other studies (Hedin LW & Janson PO (2000) Domestic violence during pregnancy: the prevalence of physical injuries, substance use, abortions and miscarriages. Acta Obstetricia et Gynecologica Scandinavica 79:625-630) so that without private consultation with a medical doctor at a clinic or hospital the severity and volume of domestic abuse and ill-treatment of women could have increased as the data shows suggesting a negative impact for women and girls accessing these services. The UK Government indicates the cost of domestic abuse to be £47 billion annually (https://www.gov.uk/government/publications/the-economic-and-social-costs-of-domestic-abuse) which demonstrates it does not fully know the reasons for male violence or its prevention and so must consider (preventable) abortion as a significant factor. 2) Women’s safety has further been compromised without a clinic appointment because it gives men power and control in relationships who could have coerced their partners into telephoning for abortifacient pills when women may not have wanted to end their pregnancy or were unsure which could have been disclosed at a clinic in addition to other abuse. An online survey by the Abortion Recovery and Care Helpline (ARCH) found 75% of women believed they had in some way been coerced or pressured to undergo abortion by a partner at some time (https://www.spuc.org.uk/News/ID/384503/Explosive-Mumsnet-post-reveals-how-UK-men-are-trying-to-force-women-to-have-abortions). It is important men know their behaviour could be checked by disclosure to authorities in person. Coercive abusive relationships may mean women did not receive or were too afraid to call for prompt medical help which could have meant worse health outcomes meaning they were less safe and exacerbate the already unpleasant experience of losing their unborn child against their will. 3) Women have been less safe if abortifacient pills were delivered and left without confirmation under temporary measures by a courier or a husband or partner accepted/intercepted a delivery of abortifacient pills such as could happen by recorded delivery which could result in severe violence with the worst-case scenario is men subsequently kill their partner for the sake of attendance at a clinic for their safety. “The number of people killed as a result of domestic violence in the UK is at its highest level in five years.” https://www.bbc.co.uk/news/uk-49459674 4) Abortion pills could have been taken after 10 weeks’ gestation (the limit for these pills) which is a major concern for women’s safety with the temporary measures in England resulting in a number of well-publicised physical health problems for women in the national press and which could have been under-reported. Hormonal methods of contraception inhibit normal ovulation thus preventing knowledge of the gestational age of the unborn child so the temporary measures are unsafe for women since gestational age can be determined by an ultrasound scan at a clinic appointment.
	It is clear that this has a negative impact. Even without the evidence that has been gathered by various people, common sense makes it obvious that it would be bad ask round. 1) Finding out that you are unexpectedly pregnant is a frightening moment for a lot of women. Not everyone keeps an accurate record of their periods so cannot provide the information to assess how pregnant they are. This will lead to the pills being sent to women who are past the 10 week limit, sometimes by accident and sometimes because the woman may lie for any of a number of reasons. They need to be properly medically assessed for this. 2) There are many women in abusive relationships and there must be many times that they would be coerced into requesting a home abortion. They need to be assessed at a clinic to check they are choosing this of their own free will. 3) Without a face to face consultation, it is likely that pills can be requested fraudulently.

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.

Yes, positive impact on proviosn of abortion services. Triaging women before they attend has had a huge impact of delivery of care. We are able to provide extra medication with instructions again, reducing clinical follow-up.
I do not know. It is obviously more convenient for the patient.
i think it is difficult to demonstrate the positive impact on staff but there has ceratinly been no negative impact on staff working, efficiency or value for money
It's probably saving money for the workforce by not providing the service to these women. Its morally wrong
I'm sure it's made things more flexible but at a cost of making abortion more readily available with less clinical oversight.
Yes the temporary measure has had a positive impact on the provision of abortion services because of the time and money saved by the service deliverer.
Reducing face to face appointments saves time and money and enables greater access for patients who really need to be seen face to face. It allows great time and resources to be directed towards patients who have more complex needs or who later gestation.
I would imagine that the temporary measure has had a positive impact on the service as it may reduce waiting times and allow more workforce flexibility. A lot of time may be saved by having this temporary measure and therefore the healthcare professionals may have time to participate in other tasks whereas normally they would be seeing these women in clinic.
Increases the time clinicians have available to see patients
Yes much easier
Yes, it has clearly saved clinic time and therefore money.
Yes
Definitely positive in all ways: Firstly waiting lists drastically reduced, contact from experienced staff is prompt to the women/girls within days of their self-referral and even the same day if there are concerns/age/medical history. Staff. Have now incorporated triage time into their working day, if a thorough triage and safety consultation is complete and there is no need for the women/girls to attend clinic, then a courier option of medicines can be offered. Time is needed for the preparation of email to courier, preparation of medicines with two checking. If women/girls have to attend then the majority of the information is already gathered as, some women/girls have had time to read the treatment leaflets before clinic attendance and depending on the outcome of their scan, they have already decided which option is best for them (clinic times in clinic before Covid approximately 3+ hours, now 15-20 minutes). Definitely improved efficiency of service delivery as we are able to have a better flow of patients with minimal women/girls in clinic. Again giving women an informed choice of delivery of service.
Yes, it has had a positive impact. Abortion providers report that the change in regulation enables them to provide high quality care that is appropriate to the woman they are treating – rather than requiring everyone to attend a clinic for prolonged periods while the requirements of the Abortion Act are met • According to detailed large-scale analysis, the change in regulation has led to a reduction in gestation at time of treatment, coupled with no changes to complication rates. Analysis indicates that this will, in the medium to long term, reduce the costs of providing an early medical abortion service – enabling CCGs to focus on using money to improve service provision eg for later or more complex care, contraception, or STI testing • Some NHS providers have previously required women to attend multi-day appointments, or receive a referral which is contrary to NICE guidance so that their HSA1 abortion form can receive one signature – as the abortion service is run by a single doctor. They report that the change in regulation has allowed them to do this work behind the scenes – so women are not delayed or forced to attend unnecessary appointments in order to access care. • Although guidance was updated at the same time to recommend a 'scan as indicated' model for women early in pregnancy, this is not something governed by this consultation. Government should not play a role in clinical best practice, and specifically not implement rules which result in requiring women early in pregnancy to undergo transvaginal scanning.
Yes. Welsh abortion providers report that the change enables them to provide high quality care appropriate to the woman they are treating, rather than requiring everyone to attend a clinic.
Yes, obviously, for the reasons set out above.

Welsh abortion providers report that the change in regulation enables them to provide high quality care that is appropriate to the woman they are treating – rather than requiring everyone to attend a clinic either repeatedly or for prolonged periods while the requirements of the Abortion Act are met
• According to detailed large-scale analysis, the change in regulation has led to a reduction in gestation at time of treatment, coupled with no changes to complication rates. Analysis indicates that this will, in the medium to long term, reduce the costs of providing an early medical abortion service – enabling Health Boards to focus on using money to improve service provision eg for later or more complex care, contraception, or STI testing
• Some NHS providers have previously required women to attend multi-day appointments, or receive a referral which is contrary to NICE guidance so that their

single doctor. They report that the change in regulation has allowed them to do this work behind the scenes – so women are not delayed or forced to attend unnecessary appointments in order to access care.
• The current approval in Wales has enabled different services to provide abortion care in different ways – including telephone appointments and a collection service, delivery of care via remote clinics, and postage to women's houses. This has enabled them to determine the most effective use of workforce and accessibility needs locally.
• Although guidance was updated at the same time to recommend a 'scan as indicated' model for women early in pregnancy, this is not something governed by this consultation. Government should not play a role in clinical best practice, and specifically not implement rules which result in requiring women early in pregnancy to undergo transvaginal scanning.

Yes. It can allow some of the service providers to work from home. Saving on travel time and costs, and not having to interact with potentially covid infected people. People can be more flexible if they don't have to travel, but just turn on a computer and log on, so this can help with flexability when staffing issues arise.

Yes.
• Abortion providers report that the change in regulation enables them to provide high quality care that is appropriate to the woman they are treating – rather than requiring everyone to attend a clinic for prolonged periods while the requirements of the Abortion Act are met
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Very much so. Telemedicine allows for greater flexibility in services which can run online and on phones 24/7 rather than during limited hours in person. It reduces costs and transport needs for both the providers and the women accessing the service.

Welsh abortion providers report that the change in regulation enables them to provide high quality care that is appropriate to the woman they are treating – rather than requiring everyone to attend a clinic either repeatedly or for prolonged periods while the requirements of the Abortion Act are met
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The flexibility of the measures have led to many women being able to receive the heath care they require with much more ease than would they would have experienced without the services. As previously mentioned, the freedom of being able to stay at home results in the procedure being much more comforting but also a speedier process as there is less of a requirement to make appointments to discuss the matter at hand which in turn saves health boards money as doctors can instead focus themselves on pregnancies that are in a further term, issues such as contraception and more making their work more efficient.
Yes
Yes, requiring women to take up unnecessary resources can only put a strain on the NHS
Welsh abortion providers report that the changes have enabled them to provide high quality care that is tailored to the woman they are treating, rather than forcing them to attend a clinic either repeatedly or for prolonged periods while the requirements of the Abortion Act are met, resulting in a much more patient-focussed experienced. According to detailed large-scale analysis, the changes have led to a reduction in gestation at time of treatment, along with no changes to complication rates. Analysis indicates that this will, in the medium to long term, reduce the costs of providing an early medical abortion service, enabling Health Boards to reinvest the savings in other clinical services. Some NHS providers have previously required women to attend multi-day appointments, or receive a referral which is contrary to NICE guidance so their HSA1 abortion form can receive one signature – as the abortion service is run by a single doctor. They report that the change in regulation has allowed them to do this work behind the scenes, so women do not have to ""jump through hoops"" in order to access care. The change in regulations in Wales has enabled different services to be flexible in how they provide abortion services, including using telephone appointments and a collection service, delivery of care via remote clinics, and postage of treatments to women's homes, allowing them to decide and implement the most effective use of resources to serve their clients in a patient-focussed and appropriate way. Although guidance was updated at the same time to recommend a 'scan as indicated' model for women early in pregnancy, this is not something governed by this consultation. Government should not play a role in clinical best practice, and specifically not implement rules which result in requiring women early in pregnancy to undergo transvaginal scanning.
Yes as it is a more flexible service and therefore more accessible
Welsh abortion providers report that the change in regulation enables them to provide high quality care that is appropriate to the woman they are treating – rather than requiring everyone to attend a clinic either repeatedly or for prolonged periods while the requirements of the Abortion Act are met • According to detailed large-scale analysis, the change in regulation has led to a reduction in gestation at time of treatment, coupled with no changes to complication rates. Analysis indicates that this will, in the medium to long term, reduce the costs of providing an early medical abortion service – enabling Health Boards to focus on using money to improve service provision eg for later or more complex care, contraception, or STI testing • Some NHS providers have previously required women to attend multi-day appointments, or receive a referral which is contrary to NICE guidance so that their HSA1 abortion form can receive one signature – as the abortion service is run by a single doctor. They report that the change in regulation has allowed them to do this work behind the scenes – so women are not delayed or forced to attend unnecessary appointments in order to access care. • The current approval in Wales has enabled different services to provide abortion care in different ways – including telephone appointments and a collection service, delivery of care via remote clinics, and postage to women's houses. This has enabled them to determine the most effective use of workforce and accessibility needs locally. • Although guidance was updated at the same time to recommend a 'scan as indicated' model for women early in pregnancy, this is not something governed by this consultation. Government should not play a role in clinical best practice, and specifically not implement rules which result in requiring women early in pregnancy to undergo transvaginal scanning.
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The impact has been positive. In our service it has allowed the re-housing of the entire service into a different space making acute hospital space available for other care. DNA rates are down or don't impact as much within a setting of a virtual waiting room for consultations. It offers working hour flexibility to staff as they do not need to work on site or when other colleagues are around (for staff safety) to provide telemedicine appointments.
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I imagine so. Faster referrals and timelier provision.
Yes. It has reduced waiting times, length of care needed, appointment times etc. All leading to the services being able to provide a better service and better value for money.
It has made the delivery of abortion services more efficient due to the lack of need for appointments.
I imagine so, as it provides them frees up time for them to deal with more complicated cases and allows them to deliver treatment in a much more effective and timely manner. It potentially also speeds up response times so terminations can be carried out much earlier on, which can have a positive knock on effect for the health service as it removes the long term risk of the possible physical and mental harm caused by having to experience an unwanted pregnancy.
According to detailed large-scale analysis, the change in regulation has led to a reduction in gestation at time of treatment, coupled with no changes to complication rates. Analysis indicates that this will, in the medium to long term, reduce the costs of providing an early medical abortion service – enabling Health Boards to focus on using money to improve service provision eg for later or more complex care, contraception, or STI testing
Yes.
Yes, I think those involved might be freer to focus more on education to prevent unwanted pregnancies, better guidance for those who are unsure on their options and any post treatment that might be needed.
Yes, of course it has.
Yes it saves time and money and makes access easier.
Ydw
Of course it has. Being able to be at home enables women to be productive if they want. It also helps recovery times as you are just able to relax and let your body process the abortion in a stress free and relaxing environment. It can be incredibly draining and stressful for some women to go through the process in a clinical setting.
Only in the sense that it has allowed a more concentrated effort on dealing with the pandemic.
I am not involved in service delivery, but it seems logical that this is a more efficient and cheaper way of delivering the service than previously.
Yes. Makes clinics less busy, and frees up staff to care for people who have a medical need to terminate in a clinical setting.

Yes, we can deal with a lot more patients than we would if all being seen face to face and also don't need quite as many staff to cover this particular aspect of the service.
I believe the temporary measures have increasing efficiency of service delivery as women are receiving the treatment they request at an earlier gestation. Having the option for women to complete a termination at home also benefits the Health Board by saving money and time on patient admission or longer face to face appointments. Further training may be required in order to maintain this service so that staff can become more confident and comfortable assessing and advising on at home terminations. Any change in service delivery can sometimes be daunting, some staff may feel less confident on e-consults, for example, therefore on going support should be offered to staff to maintain new clinical skills.
The temporary measure has had a positive impact under the shadow of the coronavirus, as it reduces the risk of transmission; but it has had a negative impact regarding patient care, as consultations only occur over the phone. The in-person element of health care for pregnant women and girls is vital, so that both physical and mental health issues can be talked about in an environment where privacy is ensured.
Abortion providers across Wales report that the change has enabled them to reduce waiting times, minimise the need for repeat visits or referrals via other care, and reduce gestational age at which abortions are provided. They also report that they have been able to provide high quality care that is appropriate to the women that they are treating. The increase in earlier gestation abortions means that there will be a reduction in cost as a result. The current approval has enabled different services to provide abortion care via telephone appointments, a collection service and post. This has enabled services to determine most effective use of workforce and accessibility needs locally.
Yes, since it does not involve any personal interaction with the providers.
Yes, it has had a positive impact. ● Doctors for Choice UK members are unanimous in their support of telemedicine in abortion care. This is because it allows us to provide better quality care to women and pregnant people who need an abortion – rather than requiring everyone to attend a clinic for prolonged periods while the requirements of the Abortion Act are met. ● The regulations allow for greater workforce flexibility - allowing doctors who are shielding, or self-isolating, or with childcare commitments to work from home, leading to a more efficient and cost effective service. ● NICE recommends a waiting time of no more than one week between request and assessment and another week between assessment and procedure. Data from BPAS show that the waiting time for an abortion through their service was reduced by 50% to just two days 7 . ● Publicly available data from the RCOG (which collated data from independent sector providers, who provide about 75% of abortions in the UK) show that the average waiting time for an abortion has halved during the time of data collection, reducing to 4.5 days.
The effect has been positive - services can work more flexibly and allow staff to work at more varied times of day and from other locations e.g. if they are shielding. It has allowed for ultrasound to be used only when clinically necessary rather than as a blanket test for everyone when it is not needed, reducing costs.
yes
Yes although the research did notlook at staff experience, anecdotally I have been told that the reduction in travel time and cost has been beeficial and staff soon became skilled at telephone consultations.
Yes
For service providers, this way of working has bought efficiencies so that waiting times have been reduced across Wales, when we have struggled for years to do this. Using telemedicine to screen all women for co-morbidities has meant a more prompt and convenient service to the patient as they can be placed with the right clinician first time, and any arrangements such as referral or consultation with other doctors can be done in advance of the appointment. It has provided an opportunity to introduce other service changes, such as reduced numbers of scans, less use of anti D without any reduction in quality.
Yes. I think it allows clinicians and nurses to be used elsewhere in other areas of women's health. Having the reduction of patients visiting the service will reduce the amount of staff required daily to cover the clinic. The need for bed space will decrease and therefore money can be saved and utilised elsewhere. It makes it easier for some people to access the service if it is done over the phone. They will not need to get to and from appointments which will be a big bonus for some women, especially if they rely on public transport/ friends or family to provide transport. By having access to the service over the phone can prevent any delay in treatment being offered and given.
Yes, the new arrangements have utilised nursing skills in triage, assessment, communication, information giving and psychological support. Nurses have been able to facilitate safe and effective Early Medical Abortion in a way that has been welcomed by women and is rewarding for healthcare professionals. It has also meant that more time and resources are better utilised, for women who have complicated medical needs or who require a greater level of support and intervention. This represents a person-centred and flexible efficient use of resources.
Yes. With the pressures on our NHS anything that is going to lead to a simpler, faster and easier way to help the clients is bound to be of benefit to the providers.
• Welsh abortion providers report that the change in regulation enables them to provide high quality care that is appropriate to the woman they are treating – rather

than requiring everyone to attend a clinic either repeatedly or for prolonged periods while the requirements of the Abortion Act are met • According to detailed large-scale analysis, the change in regulation has led to a reduction in gestation at time of treatment, coupled with no changes to complication rates. Analysis indicates that this will, in the medium to long term, reduce the costs of providing an early medical abortion service – enabling Health Boards to focus on using money to improve service provision eg for later or more complex care, contraception, or STI testing • Some NHS providers have previously required women to attend multi-day appointments, or receive a referral which is contrary to NICE guidance so that their HSA1 abortion form can receive one signature – as the abortion service is run by a single doctor. They report that the change in regulation has allowed them to do this work behind the scenes – so women are not delayed or forced to attend unnecessary appointments in order to access care. • The current approval in Wales has enabled different services to provide abortion care in different ways – including telephone appointments and a collection service, delivery of care via remote clinics, and postage to women's houses. This has enabled them to determine the most effective use of workforce and accessibility needs locally. • Although guidance was updated at the same time to recommend a 'scan as indicated' model for women early in pregnancy, this is not something governed by this consultation. Government should not play a role in clinical best practice, and specifically not implement rules which result in requiring women early in pregnancy to undergo transvaginal scanning.
yes, improved efficiency- reduced hidden costs for patients, improved access for young and poor helped workforce flexibility and safety (for staff allowing doctors who are shielding, or self-isolating, or with childcare commitments to work from home)
I imagine this to be true for all the reasons you list.
Analysis indicates that the change in regulation has led to treatment at an earlier stage of pregnancy. This is obviously better for the woman and better for the Service.
Yes
Welsh abortion providers report that the change in regulation enables them to provide high quality care that is appropriate to the woman they are treating – rather than requiring everyone to attend a clinic either repeatedly or for prolonged periods while the requirements of the Abortion Act are met • According to detailed large-scale analysis, the change in regulation has led to a reduction in gestation at time of treatment, coupled with no changes to complication rates. Analysis indicates that this will, in the medium to long term, reduce the costs of providing an early medical abortion service – enabling Health Boards to focus on using money to improve service provision eg for later or more complex care, contraception, or STI testing • Some NHS providers have previously required women to attend multi-day appointments, or receive a referral which is contrary to NICE guidance so that their HSA1 abortion form can receive one signature – as the abortion service is run by a single doctor. They report that the change in regulation has allowed them to do this work behind the scenes – so women are not delayed or forced to attend unnecessary appointments in order to access care. • The current approval in Wales has enabled different services to provide abortion care in different ways – including telephone appointments and a collection service, delivery of care via remote clinics, and postage to women's houses. This has enabled them to determine the most effective use of workforce and accessibility needs locally. • Although guidance was updated at the same time to recommend a 'scan as indicated' model for women early in pregnancy, this is not something governed by this consultation. Government should not play a role in clinical best practice, and specifically not implement rules which result in requiring women early in pregnancy to undergo transvaginal scanning.
Yes, it de-medicalises this issue and follows the principles of prudent healthcare i.e. minimum possible intervention.
It has been much easier for those working in abortion services to provide such care, with much greater flexibility and efficiency.
Clearly, being able to offer a remote service helps the healthcare workers and service. Many doctors work across differnt areas and different sites. This allows for work to be done from home or other sites without the need to physcially be on site/ travel to the unit therefore meaning greater flexibility. The fact that waiting times are lowered means a more efficient services in general and reduces the chance of backlogs or crisis with things like staff sickness. It also is money, time and space-saving for the clinic to be able to conduct some of the consultations remotely, and given the strain on the NHS these things can only be welcomed.
Yes. All of the above. And well-being of the pregnant person, giving them this option.
Yes as a Health Board providing abortion care we have found the change in regulation has allowed our service to move forward and focus more on patient centred care. As Consultations are now on the whole remote, we are able to focus more on patient care rather than scheduled appointment time. Time taken for previous booked clinics can now be used for development of services, such as contraception, and counselling services.

I do not think it has had a lot of impact for service delivery, though in the pandemic it reduces the number of people who come into physical premises.
Hard to say - those who need to work from home for health reasons can continue to be part of the service provision, which must have helped with any capacity issues.
Yes, it has had a positive impact. ● It allows HCPs to provide better quality care to women and pregnant people who need an abortion – rather than requiring everyone to attend a clinic for prolonged periods while the requirements of the Abortion Act are met. ● The regulations allow for greater workforce flexibility - allowing doctors who are shielding, or self-isolating, or with childcare commitments to work from home, leading to a more efficient and cost effective service. ● NICE recommends a waiting time of no more than one week between request and assessment and another week between assessment and procedure. Data from BPAS show that the waiting time for an abortion through their service was reduced by 50% to just two days. ● Publicly available data from the RCOG (which collated data from independent sector providers, who provide about 75% of abortions in the UK) show that the average waiting time for an abortion has halved during the time of data collection, reducing to 4.5 days.
Allows a greater range of healthcare professionals to be involved in abortion care and work remotely at home - particularly important for shielding doctors and nurses. Waiting times have drastically decreased and this improves cost. NICE noted that the reducing waiting times by just 1 day saves England 1.6 million pounds, the waiting times have decreased further than one day so the savings to the NHS are huge.
Especially during pandemic - less physical access to face to face services needed. Ability of staff who are shielding to be able to offer healthcare provision from home. Less time required from staff to provide abortion care via telemedicine versus face to face - therefore allowing staff more time for other healthcare. More streamlined ability to administer care and medication. Overall would offer money saving to NHS. Studies have shown that women are accessing abortion at earlier gestations - therefore the lowest cost treatment and less overall health issues for women either from pregnancy or abortion = less costs to the NHS.
Ydw. Mae tystiolaeth gan darparwyr gwasanaethau erthyliad yn dangos bod y drefn hon yn llai costus, yn fwy hygyrch, yn fwy effeithlon a hyblyg.
In addition to service users, the EMA at home model has significant benefits for healthcare professionals who provide abortion care services, and for the healthcare service itself in terms of service efficiency and value for money. 1. Positive impact on clinicians The reduction of in-person appointments has permitted clinicians and administrators to reduce their risk of coming into contact with COVID-19. This has been crucial not only to ensure clinicians' and administrators personal safety but also to allow appropriate staff numbers to be maintained. This can be contrasted with many other parts of the NHS which saw significant staff shortages after staff became unwell or were required to self-isolate. Clinicians also benefit as there is less likelihood they will be harassed or intimidated by protesters outside clinics, which unfortunately is a frequent occurrence. (See for example: https://www.fsrh.org/documents/rcog-fsrh-submission-home-office-review-protests-abortion-clinic/rcog-fsrh-submission-home-office-abortion-clinic-protest-review-2018.pdf) However, because EMA at home model constitutes a substantial change to the delivery of abortion services, clinicians involved in providing abortion and/or post abortion care are likely to need guidance on the new arrangements, including on the safety and efficacy of this model. Given the speed at which a decision was required at the beginning of the pandemic, it is understandable that guidance was lacking at this time. Should the approval become permanent, clear guidance must be published. 2. Positive impact on service efficiency Providers have reported that the EMA at home model permits clinicians and administrators to manage clinics more efficiently. Time is saved by, for example, reducing the need for clinically unnecessary appointments, making it less likely that patients will be late or unable to attend appointments, and by reducing time spent making and rearranging appointments. This frees up clinicians' time and permits them to spend more time with patients who have more complex needs. The EMA at home model also allows more time for women to consider their options between and after appointments. With more information provided in written and audio-visual formats at the initial presentation, women can take more time reflect on the information and ask any pertinent questions as part of the telemedicine consultations. Previously this would all have been done face-to-face which can be stressful. A further benefit is a more efficient certification process. One of the demands of the previous pathway, where mifepristone had to be administered in clinic, was the need to find a second registered medical practitioner to certify the abortion. Rather than keeping women waiting while a second doctor is found, this process can now be done without delay. This is often not a problem for independent sector providers, but doctors working in the NHS have a variable caseload and often see a mix of patients with different needs.

Providers also note that during the pandemic some staff were able to be redeployed to assist with COVID-19 efforts, indicating the EMA at home model requires fewer staff.

3. Value for money

A health economic analysis, undertaken by the Royal College of Obstetricians and Gynaecologists (RCOG), demonstrates a number of cost efficiencies with this new pathway. The evaluation adapted the economic model produced for the NICE Guideline on Abortion Care. All parameters from the NICE model were updated to the more recent or applicable evidence and to enable the comparison of the telemedicine model of care compared to the former pathway for early medical abortion. By reducing the waiting time between initial presentation and the abortion procedure, and thereby reducing the gestation at which abortion in done, savings could be made by allowing women to choose between the simpler medical rather than surgical procedure and between expulsion at home or in a more costly clinical setting.

For the independent sector in England and Wales, the modelling shows estimated cost savings are £15.80 per abortion, representing a saving to the NSH of over £3 million per year. The abortion procedure cost saving represents almost two thirds of the overall cost savings. Over a third of the total cost savings come from a reduction in incomplete abortions.

For NHS trusts, the modelling shows telemedicine is a cost-effective model of care which can be adapted straightforwardly for Trusts which may not currently provide this service. As with the Lothian data, cost savings to the NHS are likely to be higher given the overhead involved in providing hospital-based care.

yes - the reduction in continuing pregnancies and of serious complications is evidence of reduced workload from complications of abortion. The move to telemedicine has also enabled more flexible working for those with child care responsibilities or who have health conditions (currently self-shielding). This leads to more efficiency in the use of health care staff and therefore more cost-effective service.

I would have thought it self-evident that this service would be more cost-effective.

Yes, this has improved the efficiency of the service.

It has offered flexibility. It has reduced face to face contact during the pandemic. All in all, the outcomes are positive for staffing adn resources.

The temporary measure has had a positive impact on the provision of abortion services for those involved with service delivery.

In November 2020 the Women's Health CPG wrote to the Deputy Chief Medical Officer, Chris Jones with information of evidence presented to us in a meeting of June 2020. In this meeting we heard from Welsh abortion providers who reported that the change in regulation to allow telemedical abortion has been revolutionary for them – it has enabled them to streamline the process for clients, helped to avoid delays, reduce waiting times and waiting lists, and reduce the gestational age of terminations and thus the complication rate.

NHS services have reported that telemedicine has enabled them to provide services when staff have been redeployed to deal with Covid-19 – indicating that high quality abortion services can now be provided with fewer staff. Telemedicine in Wales has been accompanied by changes in some areas to ensure that the legally-required signatures for abortion forms can now be provided in-service. This means that there is less pressure on sexual health, contraceptive, and GP services – and less chance of delays for women who present without the required signatures.

Prior to the change in regulations, clients were required to attend services for prolonged periods – for face to face consultations, scanning, two doctors' signatures, and administration of mifepristone. Although the change in regulation concerns only the administration of mifepristone, the change has enabled providers to reconsider how services are provided and determine for themselves the most effective use of workforce and accessibility needs locally.

According to the Aiken cohort study (https://dx.doi.org/10.2139/ssrn.3742277), the change in regulation has also led to a reduction in gestation at time of treatment, coupled with no changes to complication rates. Analysis indicates that this will, in the medium to long term, reduce the costs of providing an early medical abortion service – enabling Health Boards to focus on using money to improve service provision e.g. for later or more complex care, further reduction in waiting times, better provision of contraception, or wider STI testing.

Although guidance was updated at the same time to recommend a 'scan as indicated' model for women early in pregnancy, this is not something governed by this consultation, nor should it be. The only places in the world that have considered implementing the requirement to undergo ultrasound scanning in law are in the USA, where the ultimate aim is to deter women from accessing abortion care at all. Government should not play a role in clinical best practice, and specifically not implement rules which result in requiring women early in pregnancy to undergo transvaginal scanning, which can be invasive and physically and emotionally challenging for clients.

Abortion services in England and Wales are largely provided by charitable organisations, such as the British Pregnancy Advisory Service. The staff working for these organisations feel very strongly about improving access to reproductive healthcare, so any move in this direction will have a positive impact for those involved

with service delivery. It will also, inevitably, create more working flexibility for them - working from home, for example.

The system benefits are also clear. Telemedicine saves money, which can be redistributed to improve other health services. As such, even if one were to set aside the clear medical evidence in favour of telemedical provision of early medical abortion, a simple cost-effectiveness consideration would lead to the same conclusion. In sum, there are really no downside to these changes.

Yes, it has had a positive impact. Remote services, community services and reduced waiting times have improved access for all women, and fewer women have felt the need to access an abortion through an alternative, illegal service.

The change has had a positive impact.
Abortion providers have variously described the changes in regulation as 'revolutionary' and 'one of the success stories of the pandemic'. The change has enabled services in Wales to provide safe and effective services that are more accessible than ever before.
NHS services have reported that telemedicine has enabled them to provide services when staff have been redeployed to deal with Covid-19 – indicating that high quality abortion services can now be provided with fewer staff.
Prior to the change, clients were required to attend services for prolonged periods – for face to face consultations, scanning, two doctors' signatures, and administration of mifepristone. Although the change in regulation concerns only the administration of mifepristone, the change has enabled providers to reconsider how services are provided and the needs of clients.
According to detailed large-scale analysis, the change in regulation has led to a reduction in gestation at time of treatment, coupled with no changes to complication rates. Analysis indicates that this will, in the medium to long term, reduce the costs of providing an early medical abortion service – enabling Health Boards to focus on using money to improve service provision e.g. for later or more complex care, contraception, or STI testing. In NHS services, these savings are particularly notable as a result of the reduced need for theatre space, day beds, and under pressure speciality professionals such as anaesthetists.
No matter the change in regulation around the location where a woman can administer the first pill in an Early Medical Abortion, BPAS had already started to move towards scanning only as indicated as a service improvement prior to the COVID-19 pandemic. BPAS will not be reverting to routine scanning, which is not clinically indicated, can be invasive (particularly if transvaginal, as is often the case in early pregnancy), and physically and emotionally challenging for clients. Based on our conversations with other providers, including those within NHS services in Wales, this is also their intention.
This change has led to the provision of higher quality clinical care, and no matter where women are allowed to take abortion medication, clinical services will not be going back to their previous methods of provision.

Yes. There is evidence that some patients, for many health conditions, delayed accessing health care treatment during the pandemic. Offering this service enabled patients to get the care they needed in a timely manner, without risk of contracting Covid-19.
https://www.health.org.uk/news-and-comment/charts-and-infographics/non-covid-19-nhs-care-during-the-pandemic

The temporary measures allowed us to increase capacity, and to spend more time with the complicated patients. This is better for patients and better for the staff, who feel that they can provide better care.
The temporary measures have reduced gestation, which nothingness abortion safer, but also makes it less costly and easier to arrange. Earlier abortions are less traumatic for the patient also less traumatic for the staff in clinic.

yes.
Same reports suggest better professional time use, and therefore better value to provider (usually NHS)

The data collected about care provided by telemedicine during the pandemic in England and Wales illustrates that mean waiting time was significantly reduced – it was 4.2 days shorter on average (Aitken and others 2021). This is really important because delays, no matter how short, can sometimes result in a person missing the time limit for medical abortion (Lohr and others 2020). An additional important point is that enabling remote care (which is not possible without home use of both abortion medications being lawful) means that clinic time can be prioritised more effectively for those who really need it – including those who would prefer in-clinic care, but also those who might need it for health reasons. This can ensure that all persons – including those who really need additional care – get access to the appropriate care sooner, which of course can minimise risks to health.

Organising the service this efficiently can also have service-level benefits including minimising costs, and affording flexibility to healthcare workers. It also minimises the substantial administrative burden that results from the two doctors' signatures requirement for abortion.

Reference:
Lohr, P and others. 2020. 'How would decriminalisation affect women's health?' in S Sheldon and K Wellings (eds), Decriminalising Abortion in the UK: What Would it Mean? Bristol: Bristol Policy Press.

Yes I feel it has been positive. Health care providers have reported that they have been able to provide a more efficient service that requires less staff.

Doctors for Choice UK members are unanimous in their support of telemedicine in abortion care. This is because it allows us to provide better quality care to women and pregnant people who need an abortion.

NICE recommends a waiting time of no more than one week between request and assessment and another

week between assessment and procedure. Data from BPAS show that the waiting time for an abortion through their service was reduced by 50% to just two days (1). Publicly available data from the RCOG (which collated data from independent sector providers, who provide about 75% of abortions in the UK) show that the average waiting time for an abortion has halved during the time of data collection, reducing to 4.5 days. Other advantages include: - More efficient clinics. - Allows us to give additional time to clients with more complex needs attending clinics in person. - Self-referral for telemedicine appointments means there is less pressure on sexual health and GP-services. (1) BPAS (2020) Pills by Post: Telemedical Abortion at the British Pregnancy Advisory Service. Available at <https://www.bpas.org/media/3385/bpas-pills-by-post-service.pdf>
As a senior clinician and also within my role as membership secretary of the British Society of Abortion Care prtoviders I network with a large number of healthcare professional who workin abortion care and literally everyone I know feels that the temporary chnage in regulation has brought positive change for the service users and for the population. Similalry I find a universal wish to keep the option for delivering remeote access care - or telemedical - abortion care when the COVID pandemic is over. There is a recognition that we do want to return to offering greater choice - so that the small minority of women who prefer to have their 1st contact face-to-face/in-person get this . We can hope for a time when clinical judgement based on evidence alone - not hampered by regulatory or legal requirements - are the factors influencing care. Reduced waits and earlier abortion also saves the nation money - NICE Abortion 2019 found that for every day's reduction in waiting time, the NHS in England would save £1.6m per year owing to reduced complications and fewer needing to opt for a surgical abortion Allowing doctors to prescribe from home has been valued part fo the temporary regulation and we would like to see this remain as it increase the scope for doctors to work flexibly and efficiently
dont know
It shouldn't even be happening.
No. Taking part in abortion procedures is always negative, and to off-load responsibilities onto the woman or girl who is to have her child killed in this way seems to demonstrate a cowardice and unwillingness to face responsibility for the deaths that occur. This will always have a negative effect on abortion providers. All public expenditure on the dismemberment or poisoning of pre-birth citizens is money wasted and diverted from its proper purpose, therefore any reduction by reintroducing unsupervised back-street abortion under a different name is merely wasting less money on a fatuous and nihilist programme of legalised slaughter.
Nothing to respond to.
Don't know
No.
I do not think that there has been any positive impact for those involved with the service delivery because they have essentially been removed from the picture and there are no medical professionals physically present with women when they are carrying out their own abortions at home.
No. It makes it too easy, while filling the pockets of the abortion providers.
No comment.
It only determines that their role in safely guiding women through this traumatic event is not necessary- it is dangerous and whilst it may appear to lesson pressures on services, uptake will inevitably increase due to the easy nature of diy abortion. This will cost the NHS. Plus complications that go unnoticed or unmonitored will soon give the image of a health service that doesn't care for women's safety.
Those are all minor matters compared with the problems I mentioned above.
Abortion, this being the killing of an unborn child is a grave sin. The provision of early abortion to save money is equally a grave sin. Please see my reply to Q1.
It has had a negative impact because it cheapens life. A quick phone call to end a human life for free or cheaply. the longer the time required to consider the implications of executing a child in the womb, the better.
No. How can the abortion of a foetus be described in anyway, in terms of "" value for money""
No, unless the government is thinking shopping online I fir convenience. We are talking about ending another life here. An unborn child. Stopping someone's heartbeat.
It is a time-bomb. Does anyone know what affect this abortion 'service' will have on the females to use them? Will they be able to carry a child in future should they so wish? Where is the foetus being disposed of? i UNDERSTAND IT DOWN SEWERS AT THE MOMENT BUT THAT COULD JUST BE GOSSIP. HORRENDOUS IF TRUE.
easy access to abortion will cause more harm than you think, human life is priceless and we are not in charge to decide whether to have an abortion or not, it's all in hands of God - he gives life and also terminates it whether you believe or not - you must not allow to kill unborn babies in the name of the law!
The women using the service should have the greatest consideration, not the convenience issues around the service delivery or value for money.
No, becuase abortion is a murder.
No, becuase abortion is a murder.
No for the same reasons as above it is too easy women to complete without truly thinking through their decision.

I am sure this has been more easy for those providing abortion facilities. However I have no knowledge of the cost of these pills as compared with the cost of normal provision. The real cost is the death of a baby and most probably the future mental health of the mother.
I do not have knowledge to answer this question but value for money, greater workforce flexibility etc should never be a deciding factor when discussion is around such sensitive subject as pregnancy termination, impact of it on woman's health and wellbeing.
No comment - I lack experience or insight into this
No. Providers are not able to give informed advice. Coercion is not likely to be noticed.
These questions are pretty offensive ..... a great assumption is made that everyone who reads this thinks that having an abortion is the same as having a not-necessary-for-life body part removed. If you could get rid of tonsils with a pill, of course just doing a telephone consultation and posting the pill would save time and money, as well as putting a fair few people out of work. But we are talking chalk and cheese here. Case Study ..... a good friend's partner had an abortion, they agreed this baby didn't fit in with what they wanted from life at the time, and laughed it all off as 'it' was just a bunch of cells. Four wanted-children later the friend found someone else to spend the rest of his life with and she became pregnant, this time his new partner miscarried and my friend's grief was compounded when he realised that there was no difference between the two babies. He had agreed to end the life of his first child with no thought. As I say, offensive questions .... laws about ending a life should not be decided in terms of value-for-money/efficiency/workforce considerations. We are still fighting to save lives from Covid, much talk about the weak and vulnerable. 100,000 people have died in the last year in the UK. In 2019, over 200,000 babies were aborted in the UK.
Cannot comment
There has been a negative impact in that the measure may lead to abortion pills being prescibed inappropriately, for instance to women whose pregnancy is more advanced than the pills are suitable for. This has actually happened.
No comment
I'm sure it has been much more efficient and much cheaper to deliver - but that does not always mean that it is better. Cutting corners, providing medication and turning away does not help women at the most vulnerable times of their lives. They need support and someone to come alongside them to go through the journey with them, not just handed a pill and told to get on with it.
No, it's imorral and at its simplest, relinquishes those who should have care and compasion to help support and provide the right outcome, including protecting the interests of the unborn featus, with any form of responsibility. We can't simply give a pill for every problem humanity faces - wake up! There are long term consequences that simply providing an easy pill with no other support and help in person would create.
I feel that it is convenient for the females needing this medication, but dangerous for the medical staff that are prescribing and allowing it to be easy to access.
No! Since when did things like service flexibilty, and value for money trump patient safety and security?
Services are more flexible for staff especially because of the possibility of home office working for clinicians.
Not sure on this.
NO. 'efficiency of service delivery, value for money etc'. There is no advantage if the woman subsequently requires a hospital admission after taking a home abortion pill which doesn't work properly
No
No
No The telephone consultation process and access at home means that there is less oversight of the process in terms of legality. It would also affect staffing at clinics as there will be less need for staff.
No. The temporary measure has divorced healthcare professionals from the patients they seek to care for. It has reduced the opporutunity to provide proper care for pregnant women and while it may be cheaper to kill children in the womb by answering a call and posting out some pills, it is certainly not ensuring that staff can give proper care to their patients.
No. Systematic population control
Most healthcare professionals will not be satisfied with these services as they know women cannot be properly or safely assessed by telephone to ensure that they are eligible for the abortion treatment at home. Caring professionals thrive on personal contact with their patients, including informal interactions which are not possible with telemedicine. Costs may be reduced with telemedicine abortions, but this is not worth the lack of due care and compromising of safety, with possible complications.
killing the unborn is wrong. full stop!
The provision of abortion without an in-person appointment increases the potential for harm to women at risk of coercion. Without a mandatory in-person appointment it will be difficult to ensure that all women receiving pills are doing so freely, without coercion.
Most healthcare professionals will not be satisfied with these services as they know women cannot be properly or safely assessed by telephone to ensure that they are eligible for the abortion treatment at home. Caring professionals thrive on personal contact with their patients, including informal interactions which are not possible with telemedicine. Costs may be reduced with telemedicine abortions, but this is not worth the lack of due care and compromising of safety, with possible complications.
Tell the Welsh government to end DIY abortion immediately
Nac ydwyf

This provision does not need to be continued as with the Vaccine roll out we should hope that face to face ,behind masks consultation will be available to women who are pregnant .
-
My answer to Question 1 would still apply here.
Most healthcare professionals will not be satisfied with these services as they know women cannot be properly or safely assessed by telephone to ensure that they are eligible for the abortion treatment at home. Caring professionals thrive on personal contact with their patients, including informal interactions which are not possible with telemedicine. Costs may be reduced with telemedicine abortions, but this is not worth the lack of due care and compromising of safety, with possible complications.
While this temporary measure will surely reduce the workload for those involved, if they don't have to assess the patients, the lack of face-to-face, that is not a reason to make such a dramatic, unsafe change in practice. Knowing you provided substandard care, that ultimately put your patient in harms way will not sit well with any responsible clinician.
No, it has had a negative impact. In person communication between medical professionals and patients is important for the best understanding and outcome. It can be hard to be sure that a women is genuinely providing consent when consultations are performed remotely. There is also a concern about proper disposal of the baby's dead body.
I am sure that the more sensitive, discerning and conscientious staff members involved in delivering this service are not satisfied with this new policy. I cannot imagine that EVERYONE involved in the provision of this service is so stupid as to know nothing of the arguments against it. I suggest surveying all staff members involved in the administration of this policy in order to get the best answer. Cheaper it may be, but can one put a cost on the suffering and death that has resulted from this policy?
NA
The idea that we should even contemplate thinking of ""abortion services"" in terms of ""workforce flexibility, efficiency of service delivery"" or ""value for money"" is simply grotesque, when one thinks of what is at stake for both the unborn life and the welfare of the mother. How far can the callousness of our representatives go?
I do not think the temporary measure has had a positive effect overall. Greater workforce flexibility etc is far less important than the woman's health.
I do not think this is value for money when so many women have had to resort to hospital treatment when the drugs failed.
I do not think this is value for money when so many women have had to resort to hospital treatment when the drugs failed.
I have no experience with this but don’t imagine that the workforce are behind it - taking the medical practitioners out of a medical assessment and procedure. They are the experts who need to be involved
no - not a good effect at all
No, it has had a very effect. Personal contact between the caring professionals and the patients is essential - this cannot be given by telemedicine. Careful assessment of the patient before prescribing is not possible under these circumstances. I can't say about costs, but if the end result is a lack of due care and possible extra emergency treatment in hospitals, then the temporary measure is certainly not worth pursuing on a cost basis.
No - It makes it easier to kill human beings without due consideration of the consequences - that is a negative impact. If your measure is maximising the number of abortions for the least amount of effort and care, the answer has to be yes - but if that is the measure why not put the pills on the shelves of supermarkets (as some lobby groups would like)?
Most Professionals are caring and know that personal contact is the best way to care for their patients, this cannot be done with Telemedicine. It compromises safety,. and may lead to complications.
Most caring healthcare professions thrive on personal contact to make the necessary judgements and would not be happy with a telephone call to help their clients make such a serious choice.
It is impossible to answer this question without relevant information regarding what has been going on since DIY abortion was introduced. How can one obtain such information?
I don't know. It may be cheaper but there is less safeguarding and emotional support.
This is a weasel question designed to get a positive answer to abortions in the privacy of the home, because clearly popping a pill in the post is cheaper and quicker than giving a woman a proper face-to-face consultation with a medical professional. Efficiency does not always deliver the best outcome. Value for money is not the most important factor when considering abortion services. What does workforce flexibility even mean? that women don't have to take time off work to care for their own health?
Most healthcare professionals will not be satisfied with these services as they know women cannot be properly or safely assessed by telephone to ensure that they are eligible for the abortion treatment at home. Caring professionals thrive on personal contact with their patients, including informal interactions which are not possible with telemedicine.

Costs may be reduced with telemedicine abortions, but this is not worth the lack of due care and compromising of safety, with possible complications.
I do not consider that the temporary measure has had a positive impact on the provision of abortion service, for those involved with service delivery. With abortion at home there is no face-to-face discussion with the prospective mother which hugely reduces the opportunity for health professionals to understand what is really happening. As one doctor has stated concerning his work as a GP, ""often as much can be gleaned from what is not said as what is spoken"". Further without a physical examination entropic pregnancies will not be detected causing serious risk to potential mothers in this situation.
I can't answer this due to lack of information.
An initial telephone consultation has meant that the average wait for initial consultation is now approximately 2 days whereas previously it was 5-10 days. Staff who have been shielding have been able to undertake safe clinical assessments via remote working. The length of appointment time is less because only patients meeting specific criteria need ultrasound scans and we are able to provide medication for collection or postage . Patients have overwhelmingly said that they feel this method of service delivery is better. In the past we had to outsource many of our referrals because we didnt have internal capacity - we have now managed to redress this with enormous savings for the health economy
No - we shouldn't be measuring efficient working practives against lives.
I do not believe that when it comes to terminating a pregnancy and killing a life, value for money efficiency of service, etc. should come into it. This cheapens life on a massive scale. I just cannot understand how easy it has become to get rid of a life just because it is inconvenient. We should teach young people rather to abstain than to abort. Abortion also brings with it tremendous mental agony/problems in later years as well as some physical problems. Some women might not be able to give birth later and they are not made aware of this.
Women cannot be properly or safely assessed by telephone to ensure that they are eligible for the abortion treatment at home. Healthcare professionals would not be satisfied with these services. Even if costs are reduced with telemedicine abortions, this is not worth the lack of due care and the compromising of safety.
There may be value for money but I question if that is the correct measure of success of this scheme. Women are more vulnerable and less supported when accessing abortion through pills by post. I think there would be less job satisfaction for the health care professionals as they are not able to actually meet the women and give them the support they need at this stressful time in their lives.
No. Most healthcare professionals will not be satisfied with this service as they know women are not properly assessed safely. The telemedicine system is open to abuse and deception. Costs may be reduced but this is not worth the lack of due care and compromising of safety, with possible complications. Cost should not be the overriding concern, and access is less important than safety.
Women can't be properly assessed by phone. No value for money compromise is worth a life.
It is sickening to me that the value of the life of the child is not even mentioned. 'Value for money' reduces the procedure to a merely economic transaction.
Most healthcare professionals will not be satisfied with these services as they know women cannot be properly or safely assessed by telephone to ensure that they are eligible for the abortion treatment at home. Caring professionals thrive on personal contact with their patients, including informal interactions which are not possible with telemedicine. Costs may be reduced with telemedicine abortions, but this is not worth the lack of due care and compromising of safety, with possible complications.
THe safety of the patient should be put first and foremost not efficiency and cost.
No i do not. I think that this has de humanized un born babies even more, and ignores the mental health of these mothers.
Most healthcare professionals will not be satisfied with the services as they know women can’t be properly or safely assessed by phone to ensure they are eligible for an abortion at home. Caring professionals thrive on personal contact with patients Which are not possible with telemedicine. Costs may be reduced with telemedicine abortions but this isn’t worth the lack of due care and the compromising of safety with possible complications.
Negative impact on the quality of service provided, especially in assessment of suitability/eligibility of clients to utilize this (home EMA) service. Since the standard of care that can be provided during and after the procedure is reduced, compared with that before the temporary measure was introduced, conscientious healthcare professionals will find it difficult to be satisfied with the service they are able to provide. In terms of 'value for money' it should be noted that even under normal circumstances, cost to the NHS of abortion services is not a large part of the overall budget. Even were this not so, monetary cost should never be allowed to outweigh safety considerations.
I have big issues with dangerous drugs being posted to vulnerable women, how do we know that the women who gave her details is the person taking them? How do we know the woman has given the correct gestational date? Surely any short term financial savings in doing this are lost in thestatistics that vulnerable women with little support are at a 81% higher risk of mental health issues further down the line.
I am amazed that you should even be putting down the phrase ""value for money."" Unborn children and their mothers are worth more than a phrase you might see in a supermarket.

How can taking the life of an unborn baby be so callously considered to have any positive impact.
No. Telemedicine may be cheaper and quicker than an in-person appointment, but the aim of medical care is not merely to adopt the cheapest or quickest approach. We must always consider the safety and wellbeing of those being served and of course compliance with the regulations. The majority of healthcare professionals will not be satisfied with a telemedicine assessment of their patient when they know that this is not sufficient to properly assess the safety and suitability of the prescribed treatment. Clinicians will be aware that they are not able to properly assess gestational age or the suitability of the abortion pills for their patients when only using telemedicine.
Workforce flexibility, efficiency of service delivery, value for money must not compromise women's safety and well being. This can only be achieved through face to face consultations.
Absolutely not! You talk about “service delivery “flexibility...and , of all things.. value for money!!!!?? Am I reading this correctly? Is that ALL a baby’s life is worth?? Saving money?! “Kill the innocent, save money “.. it’s in the way! Shame on us! A human life has inestimable value..... wouldn’t you do anything to preserve your own life? Then why not do the same thing for these innocents who are at your mercy?
Department for Health and Social Care data shows us that home-use has resulted in more abortions taking place at an earlier stage of gestation, compared to last year (https://www.gov.uk/government/statistics/abortion-statistics-during-the-coronavirus-pandemic-january-to-june-2020/abortion-statistics-for-england-and-wales-during-the-covid-19-pandemic). Earlier provision of abortion means less likelihood of complications, and so reduces the need for further service provision. Research shows us that home-use of misoprostol has a positive impact of reducing waiting times and ensuring the effective organisation of services. (Lohr et al, ‘How would decriminalisation affect women’s health?’, 2020, https://www.jstor.org/stable/j.ctv10tq4d2.8?seq=1#metadata_info_tab_contents). It must be remembered, however, that some women will want an in-person appointment in order to access face-to-face support currently provided by BPAS and MSI Reproductive Choices. Home-use must not replace in-person appointments. Women must be given a choice as to the nature of the appointment that works best for them. Funding to abortion providers should not be cut, and clinics should not be closed. Closing clinics would mean women have to travel further for in-person appointments. This would limit the availability of services and support for women; particularly those with increased vulnerabilities and with complex care needs.
I am not sure about this as I have tried to access this service with Cardiff and Vale health board and it is impossible to speak with them. I’m not sure why the Cardiff and Vale unlike BPAS/MSI all the facilities are ‘ in house’ with one administrator. The service they are providing is not the same either as opposed to ‘ pill by post’ by making people collect the medication it seems to protect the consultants but not the patients by making them travel
NO The number of emergency admissions to hospital caused by the use of the DIY telemedicine does not save the NHS time and money
he majority of healthcare professionals will not be satisfied with a telemedicine assessment of the patient when they know that this is not sufficient to properly assess the safety and suitability of the treatment. Caring professionals thrive on personal contact with their patients, including informal interactions which are not possible with telemedicine. Clinicians will also be aware that they are not able to properly assess gestational age or the suitability of the abortion pills for the patients when using telemedicine. They are not even properly checking the names and identities of the people who they are servicing. This will leave them dissatisfied with the quality of service that they are delivering. The overall cost of abortion services is a very small part of the NHS budget and though the costs may be reduced by providing telemedicine abortions, the lack of due care and compromising of safety, with possible complications mean that this is not a strong argument to continue with telemedicine abortions.
Due to the more negative aspects of clinical governancy - possible bleeding, poor mental health, no supervision and assurance when needed, no guarantee of gestation, no clear ruling out ectopic or bleeding - whatever gains may be made in workforce they are outweighed in terms of danger, wellbeing, and possibility of coercion of women receiving an at home service.
I’m not in a position to answer this question other than to say that abortion services should not be run for the convenience of the service providers.
Any convenience or value for money should not be put ahead of safety for patients.
Yes, negative impact. Telemedicine is open to abuse and deception. Where complications arise, the accessibility or convenience can be a source of regret. While it is cheaper, that doesn't take account of the full needs of the client, and we should also consider safety and compliance with regulations. Telemedicine fails to consider these other aspects. If cost is an argument then the NHS should consider removing the cost barrier.
I don’t think the tablets should be administered by post for many obvious reasons. They would be available to underage women and could get enough of the wrong hands. Abortion should never be without medical supervision
No. Too many women have not been properly, safely or adequately assessed in their telephone consultations.
Don't know

No. This dangerous procedure should never have been allowed. (Several deaths have occured as a result.)
A negative impact. Although costs may be reduced with telemedicine abortions there are risks to women's safety with this system.
As above.
No- I do not think this is safe to allow EMA by sending the pills in the post following only a telephone or video consultation and allowing women to take them unsupervised
Most healthcare professionals will not be satisfied with these services as they know women cannot be properly or safely assessed by telephone to ensure that they are eligible for the abortion treatment at home. Caring professionals thrive on personal contact with their patients, including informal interactions which are not possible with telemedicine. Costs may be reduced with telemedicine abortions, but this is not worth the lack of due care and compromising of safety, with possible complications.
The prime concern for the such a requirement must not be 'workforce flexibility, efficiency or VFM, but 'care of the person seeking the procedure.
It may be better and more convenient for those who run the service but what about the rest of society. We are deprived of 300,000 new lives a year at a time when our population already has the challenge of a disproportionally large number of elderly people. The whole abortion debate is for the convenience of a narrow group of people and anything that makes it more convenient or takes away from the reality of what it is - the taking of human life - effectively murder - is doing a disservice to both those who feel they must take this action and to wider society.
Pills on demand is flexible, efficient, cost effective and wrong.
I do not know , however I feel this a devaluing of human life and the unborn child and some of those involved may have a conflict within their conscience.
The temporary measure has proved more convenient for abortion providers and may allow the staff providers to have consultations by telephone calls from a variety of locations. On the other hand, the service provided by telephone consultations, without face to face encounters, in the long-term may have a negative impact on the ability of healthcare providers to provide a high quality service. Healthcare providers need to receive adequate training and supervision. This must always necessarily involve physical examinations and real face to face consultations with service users (in any area of healthcare and medicine). Long term use of telemedicine and telephone consultations, rather than face to face encounters, will very likely result in a significant lowering of standards in service provision and, in the long-term, will represent poor value for money. There is also a very real possibility that the absence of physical encounters with patients and service users may lead to a lowering of morale among healthcare professionals, as the job satisfaction that arises from actually meeting people and helping them deal with their complex problems will be absent. Service providers will become less empathetic and their work will become more mundane. Both healthcare professionals and healthcare users will suffer from a poorer quality service.
It is difficult for me to know the answer to this as I have never worked in the industry. However I assume anyone who does and sincerely cares about the health of women would find it worrying and frustrating that she is unable to see the woman in the flesh and truly understand her situation or mental and physical state.
I can see the administrative advantages in the current dehumanised culture, although I can see additional emotional impact on conscientious practitioners who may be concerned about particular clients without the benefits of face to face communication.
It might be better to say that 'the impacts are mixed'. The move to telemedicine and in particular the already strong and increasing sector preference for early medical abortion and expulsion at home, removes the service providers from the trauma and stigma of the abortion process. Through this approval they have become much more removed, EMA is something which their client does herself, usually way from the clinic, which for some providers helps them to not be so emotionally impacted by the work they do. We know that there is stigma associated with abortion for the providers and a remarkably high turnover of staff working at these clinics. Staff have told us that it is particularly difficult to live with, when all you do every day is terminate otherwise healthy pregnancies, simply because these are not wanted. Many staff find it difficult to tell family and friends about where they work and what they do. But nurses and clinicians didn't come into their roles, after many years of training to now spend their days at the end of a telephone, distant and remote from their patients. Clinicians are people-people and thrive on the personal, face-to-face interactions. Most would still very much prefer being able to provide quality, comprehensive care, in a client-centred, present-for-the-woman basis. This is not to deny the choice of women who wish to self-administer the abortion pills at home, but the in-clinic visit is an essential step in her overall care pathway. Yes, use telemedicine for the initial contact and as an efficient way to gather all of the basic client data and to provide the basic information, but then follow this with the in-person consultation for which these clinicians have been trained and for which they have taken up their important roles. The budgetary costs of abortion are a very small part of the overall NHS budget and we should not be considering telemedicine-enabled abortion simply to make cost savings – care for women is best when provided by professionals in a clinical setting.
I'm a vet and I don't feel satisified with teleconsults, I'm sure the medical healthcare professionals will not be satisfied with these services either - and know you can't properly and safely assess on telephone
Most healthcare professionals will not be satisfied with these services as they know women cannot be properly or safely assessed by telephone to ensure that they are eligible for the abortion treatment at home. Caring professionals thrive on personal contact with their patients, including informal interactions which are not

possible with telemedicine. Costs may be reduced with telemedicine abortions, but this is not worth the lack of due care and compromising of safety, with possible complications.
Most healthcare professionals will not be satisfied with these services as they know women cannot be properly or safely assessed by telephone to ensure that they are eligible for the abortion treatment at home.
Very negative impact as women do not have full cognizance of their decision to terminate. As a psychotherapist I regularly see female clients who are psychologically damaged by termination. They lack informed consent as the emotional consequences of their decision are not explored.
It has definately made it easier for abortion service providers - they have even less responsibilty for the misery they are inflicting on the current fertile generation. If all you are conerned about is cost then the abortion providers have it made. The NHS will have to pick up and attempt to repair damaged lives.
In my opinion none of the factors mentioned above should influence the quality of provision given to women; there can be no short-changing any woman going through this process.
Yes it makes life much easier for the provider , not the NHS where it has no impact. It makes it more efficient / profitable for the outsourced provider which means improved VFM for the NHS.
Any healthcare professional worth their salt will not be happy with a service that neglects serious safety concerns and cannot even confirm the identity of the woman requesting the service with any degree of certainty. Those who care for others desire personal contact with those they care for. This reduces contact to a call centre experience which is divorced from face to face personal care that ought to be provided and, as such, a very poor substitute and a failure in the NHS duty of care. Cost benefits should not be at the expense of safety which has been compromised.
Definitely Not . Highly dangereous.
To consider efficiency and value for money while putting mothers at risk is down right criminal. This would not be tolerated in any other service.
Most healthcare professionals will not be satisfied with these services as they know women cannot be properly or safely assessed by telephone to ensure that they are eligible for the abortion treatment at home. Caring professionals thrive on personal contact with their patients, including informal interactions which are not possible with telemedicine. Costs may be reduced with telemedicine abortions, but this is not worth the lack of due care and compromising of safety, with possible complications.
No, I do not. Most if not all medical practitioners required to take part in this proposed service will know that women cannot be safely assessed remotely. This could well play on their consciences and affect their mental health. Those who object to killing babies through abortion on religious or other ethical grounds should not have to be involved in any capacity. Some, under pressure to conform, could be lost to the profession completely.
I consider the temporary measure was introduced solely due to Covid-19. I cannot see any benefit in continuing the scheme as life returns to normal.
Most healthcare professionals will be dissatisfied with these services given that they know women cannot be properly of safely assessed by telephone to ensure they are really eligible for the abortion pills.
It has had a negative impact. The provision of abortion services is not simply a matter of convenience and efficiency. There are far more important factors relating to women's health and safety, as already mentioned. The lack of any personal and face to face consultation can alter the relationship between patients and health professionals, who will be unable to interpret non-verbal cues or develop a deeper understanding of their situation, especially in the context of such an important decision.
Providing a less safe service must surely have negative impacts on workforce well-being.
Whether abortion providers find it convenient to offer abortions remotely has little bearing on whether this practice should continue. The issue is what physical and psychological impact medical abortions, and in particular home abortions, have on those they are designed to affect in very intimate and immediate ways.
Women cannot be as well assessed by telephone to ensure that they are eligible for the abortion treatment at home. Costs may be reduced, but at the great risk of proper care and safety being compromised, with complications more likely.
None of these can compensate for unnecessary mortality
Less staff would be required for video appointments as opposed to the physical presence of staff for face to face appointments. This could be seen as a money saving measure to the detriment of women's health care. The lax arrangements could allow for some abortion providers to more easily circumvent existing laws regarding the legal conditions required for abortions and gestational time limits for abortion.
No   For those involved with service delivery, they are having to regularly face the moral dilemma of assisting women in ending the life of their unborn child. Without being able to provide proper supervision, clinical care, or consultation, due to them contacting the women over the phone rather than in person, the service provider involved will not be able to properly safeguard the woman. If any complication were to arise from the medical abortion, the service provider would then feel an immense amount of guilt, adversely affecting their mental

health as a result. It's also a concern that value for money is seen to be of such importance when considering abortions. Abortion services make up a very small fraction of the NHS budget in England and Wales, and whilst costs may be reduced with telemedicine abortions, this should not be worth the lack of due care and compromising of safety.
It has had a negative effect.
I consider the impact has been NEGATIVE. Greater workforce flexibility and value for money should not be the key criterion for deciding whether or not to make ""DIY"" Home Abortion permanent. The risks to women s well being must be the primary consideration, outweighing any supposed benefits of easier access Telephone or online access may have a negative impact on the vulnerable population eg women in domestic abuse situations who lack privacy, those suffering mental health issues, those from ethnic groups who struggle with language difficulties or those with limited ability to access technology.
In a state of lockdown, where does value for money enter into the equation? If women are working from home, this proves they are flexible. People have been furloughed, lost jobs and relationships have been put under strain. A woman faced with such prospects and predicaments might feel she has no choice other than abortion, whereas under normal circumstances, she would not have taken such a drastic measure. Where is the value for money for a woman regretting a decision she made under stressful circumstances having to use the services of a mental health practitioner after the act? This motion takes no regard for the value of human life: neither ft the expectant mothers, not her unborn child. I go so far as to day if is a conveyor belt mentality on behalf of those who allowed such legislation.
Unable to comment as not involved in service delivery.
Yes, a negative impact The telemedicine system is open to abuse and deception – the aim of medical care is not merely to adopt the cheapest or quickest approach. We must always consider the safety and wellbeing of those being served and compliance with the regulations. Where complications arise, the accessibility or convenience may well become a subject of regret.
- Most healthcare professionals will not be satisfied with these services as they know women cannot be properly or safely assessed by telephone to ensure that they are eligible for the abortion treatment at home. - Caring professionals thrive on personal contact with their patients, including informal interactions which are not possible with telemedicine. - Costs may be reduced with telemedicine abortions, but this is not worth the lack of due care and compromising of safety, with possible complications.
I would not know. I would like to know if staff feel they are adequately assessing women in a phone or video call and whether staff are confident that they can assess for pressure or ambivalence without the benefit of the full range of non-verbal communication. When it becomes known that things have gone wrong, for example if someone has used the pills outwith the time frame allowed, or when a woman suffers a serious complication, how does that affect the staff involved?
No, a negative impact 1) Healthcare workers cannot be completely certain of the safety of the people they treat simply with a telephone/video call, such as gestational age and complete medical history. The savings of a telephone call cannot outweigh the care that the healthcare professionals say themselves is necessary for this procedure such as the National Institute of Health & Care Excellence saying “providers should be able to provide emotional support after abortions. They should tell women this support is available if they need it” and “providers should provide or refer women for counselling if requested” (section 1.14.6) (NICE, 2019, Abortion care, Available at: https://www.nice.org.uk/guidance/ng140, Accessed 22 December 2020) that might be missed with just a telephone call.
Obviously, it costs less to send out pills than to make a proper assessment in a clinic, but the risks do not warrant the cost saving.

Q3: What risks do you consider are associated with the temporary measure? If you consider that there are risks, can these risks be mitigated?

access to counselling, advice and support before, during and after termination. opportunities to check in on women's mental health may be missed
Risks will be mitigated if this stops.
Emotional distress. Carrying out a DIY abortion at home is a painful and traumatic experience for women, who are often alone. Many that have been carried out studies show that women experience emotional distress after an abortion and other studies show mental health problems for women after abortion. Home abortions may lead to more adverse psychological consequences, in part because a woman may be alone when she aborts and may also see the foetus who is expelled.
Medical risks of taking pills at the wrong gestation period - with more than 50% of women having abortions after 13 weeks needing subsequent surgical intervention. Not adhering to the correct time periods between the doses - which would expose the woman to more risk of needing surgery. Home abortions may lead to even worse psychological consequences than hospital ones - with the woman alone when she aborts and left with the expelled dead baby. I know a woman who gave her expelled baby to her grandmother who buried it at the bottom of her garden and it has psychologically scarred the whole family.
Deaths. A girl who gets pregnant (and here a criminal offence has been committed, and the perpetrator ought to be brought to justice) may be only 12, 13 years away from the stage in life when the toxic poison taken in a home abortion might have killed her. If an abortion is truly an abortion, then there is no ""risk"" - the death of the pre-birth human being is a certainty, and clearly intended. The information I have seen suggests that in at least two cases the totally innocent pre-birth child was not the only one to receive death. With no medical supervision present, it is impossible to mitigate these risks: by definition, putting the operation into the hands of inexperienced people, who may have provided incorrect information in the first place, is a recipe for all kinds of tragic incidents, especially if the expectant mother decides that all is to take place in absolute secrecy and no-one else is to be aware of it. The only way to mitigate these risks is to discontinue this hit-and-miss practice altogether.
There are so many risks. Remote 'consultation' means that gestation periods are regularly wrongly estimated. Abortion performed by the woman herself is so obviously painful, both physically and emotionally, for the woman. When pills are sent through the post there is no way of establishing who eventually takes the pills, or where they might be taken. The pills might be taken by another woman ; and they might be taken anywhere -- e.g. in the back of a car, or in a public toilet. There is no way that these risks can be mitigated. They shouldn't be there in the first place.
Trained Health Profesionals are triaging women before appointments, gaining information regarding their pregnancy. those that do not require an ultrasound and have no triggers for Ectopic/Molar pregnancy, may be at risk of Ectopic/Molar pregnancy but, women are given a LSPT to do 2 weeks after the abortion to confirm sucess of treatment.
Don't know
Risk of a haemorrhage; this can be mitigated by having medical services available, but I have known girls to say nothing to their mothers and in consequence having a more severe bleed. This would worry me if the patient lived in a remote place. I believe the risk is not high.
there are no risks
Taking the abortion pills at the ""wrong gestation"", not adhering to the precise times intervals between the two stages of the abortion, and emotional distress come into play. Carrying out a DIY abortion at home is a painful and traumatic experience for women, who are often alone when she aborts and may also see the foetus who is expelled
I think it would be a massive risk, in fact potentially a disaster, to allow this temporary measure to move from being a temporary measure to being a 'normal' service.
There are many risks when a woman is taking this kind of medication without medical help at hand.
It is admittedly somewhat difficult after such a relatively short period to tell if many (or any) women will not proceed with the treatment after receiving the medications. We follow up our patients, and this acts as a reasonable safeguard against misuse or retention of unused medications. There is the risk of a woman becoming unwell at home without anyone around to assist her, however I feel our existing requirements that we ask of the patient before offering EMAH are robust enough to make this rather unlikely.
Risks of DIY 1. Taking pill at wrong time 2. Non adherence to the precise timing intervals 3. Emotional impact if carried out alone
They're are huge risks to the mothers and babies. The only way to mitigate these risks is to stop it and offer/provide other services and options to the women

Harm to health of the mother. Increase in the loss of life of unborn children. Increases on burdens on NHS. Mental health problems of women left alone to deliver their tiny child/fetus/embryo into the toilet and be traumatised as many already are when aborting in hospital. Loss of morality even further with abortion seeming even more like a method of birth control.
There is a risk that the pregnacy has already progressed beyond the legal limit as it is difficult to be precise about the date fertilisation took place. Risks are involved in the timing of taking the two pills which can lead to complications.
Abortion always has risks for the mother (let alone the child who is killed) but these are potentially multiplied when there is no professional supervision or ready care when unusual problems occur.
Women could take pills at the wrong gestation and not follow the correct time intervals between the two pills. Taking the second dose incorrectly increases the complications for the woman. Emotional distress and mental health issues are common before and after abortion but home abortions may lead to more adverse psychological consequences as woman could be alone and see the foetus expelled.
According to Right to Life, a NHS whistleblower has leaked an email that reveals that two women have died after using ‘DIY’ home abortion services. One woman died “very quickly” with sepsis whilst seeking urgent care at a hospital’s accident and emergency department after taking ‘DIY’ abortion pills. A second woman was found dead at home the morning after starting the medical abortion process. The leaked email also revealed that there is a murder investigation underway into the death of a baby delivered alive after a woman used the ‘DIY’ abortion service. This is likely the tip of the iceberg when it comes to women’s lives being put in danger and illegal late-term abortions occuring using these services. In May, it was revealed UK police were investigating the death of an unborn baby after its mother took ‘DIY’ home abortion pills while 28 weeks pregnant. In addition, abortion provider BPAS announced that it was investigating a further eight cases of women taking ‘DIY’ home abortion pills beyond the 10-week limit for medical abortions.
These measures becoming permanent as a measure to reduce costs going forward. Women are being left to make desicions with less meaningful contact with clinical services and unborn are being put at risk of death when life could have been preserved had better Clinical and support provisions been accessible.
Abortion is too easy by phone. It increases the ease and number of abortions. The negative impact on mental health on the mother can last a lifetime. More abortions means more mental health issues and the increased cheapening of life. Women have less access to medical care and mental health care. Some have died taking the pills. All this risks can be mitigated by banning medical abortions and preferably all kinds of abortion.
Women are at increased risk of coercion by being able to obtain abortion medication without a face-to-face appointment. It is impossible to verify during a phone call, or even a video call, if the woman is on her own and in a safe place to talk, without risk of being overheard. She could answer ""yes"" when asked ""are you on your own?"" when in fact, an abusive partner is sitting right by her, forcing her to make the phone call. As I already stated, it is actually impossible to verify who is making the phone call, as all you need to obtain the pills is an address to have them sent to. The undercover investigation by Christian Concern showed that women were able to obtain the pills using false identities, and abortion providers MSI Reproductive Choices (formerly Marie Stopes International) and BPAS made no checks to verify the details given to them. Since the GP does not have to be informed (it's up to the woman whether she wants them to know), it's possible that women are obtaining the pills, who are unsuitable for medical abortions due to their medical history or medication that they are taking. Once abortion medication is removed from a medical setting, it is impossible to control who takes them, and under what circumstances.
Women taking abortion pills after ten weeks of pregnancy are at more risk of harm and taking the medications at the wrong intervals or incorrectly significantly increases the risk of complications. A woman is far more likely to suffer emotional and physical distress undergoing a frightening and painful process and possibly seeing the foetus when it is delivered.
Great risks for the health of the women involved, and fatal risks for the baby involved. these can be mitigated by stopping the service.
Q1-answer
There have been risks during this temporary measure and that is the patients` health and safety, both physically and mentally!
The pills must only be taken up to ten weeks of pregnancy therefore anyone taking them later would be harmful.. There are two pills and taking them incorrectly increases health risks. The emotional impact of DIY abortions at home must have distressing consequences for the women especially if they are alone or under pressure from an abuser.
If people do not want children then they take the necessary steps to avoid pregnancy.
The emotional effect on a woman aborting alone must not be underestimated, the long term result on her mental health can be devastating. There is also the real danger that women may take these pills at the wrong gestation, causing severe complications for the mother. One UK study suggested that upwards of 50% of women aborting after 13 weeks needed surgical intervention. There is also the very real chance that women may not observe the critically important time interval required required between taking Mifepristone and Misoprostol, causing the chance of increased complications.
easy access to abortion will cause more harm than you think, human life is priceless and we are not in charge to decide whether to have an abortion or not, it's all in hands of God - he gives life and also terminates it whether you believe or not - you must not allow to kill unborn babies in the name of the law!

The risk with this temporary measure may be it's permanent acceptance and poor psychological service and provision may be perpetuated.
Risks to women carrying out a DIY abortion include: • Taking the abortion pills at the “wrong gestation”. Abortion pills are designed to be taken up to ten weeks of pregnancy, as they are less effective, and more harmful for the woman, when taken later in gestation. • Not adhering to the precise time intervals between the two stages of the abortion. The timing between taking Mifepristone (the first pill) and taking Misoprostol (the second dose) is critically important. Taking the second dose incorrectly increases complications for the woman and she may require surgery. As many as half of all recommended protocols for prescription drug use are not followed, or not followed correctly • Emotional distress. Carrying out a DIY abortion at home is a painful and traumatic experience for women, who are often alone. Many studies show that women experience emotional distress after an abortion and other studies show mental health problems for women after abortion. Home abortions may lead to more adverse psychological consequences, in part because a woman may be alone when she aborts and may also see the foetus who is expelled.
Abortion is dangerous becuase there is a high probability that during/after the abortion a woman will no longer be able to get pregnant again. I believe that the risk cannot be mitigated.
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Risks to women carrying out a DIY abortion include: • Taking the abortion pills at the “wrong gestation”. Abortion pills are designed to be taken up to ten weeks of pregnancy, as they are less effective, and more harmful for the woman, when taken later in gestation. In one UK study more than 50% of women having abortions after 13 weeks needed subsequent surgical intervention.4 • Not adhering to the precise time intervals between the two stages of the abortion. The timing between taking Mifepristone (the first pill) and taking Misoprostol (the second dose) is critically important. Taking the second dose incorrectly increases complications for the woman and she may require surgery. As many as half of all recommended protocols for prescription drug use are not followed, or not followed correctly.5 • Emotional distress. Carrying out a DIY abortion at home is a painful and traumatic experience for women, who are often alone. Many studies show that women experience emotional distress after an abortion and other studies show mental health problems for women after abortion. Home abortions may lead to more adverse psychological consequences, in part because a woman may be alone when she aborts and may also see the foetus who is expelled.
The emotion impact to these women later on after the pandemic and how easy the process is and not having proper consultation before hand.
1. There is a potential risk that ectopic pregnancies are missed through lack of routine scanning. This can be mitigated by careful assessment, scanning patients who are not clear about dates of their last period and by advising women of risks and signs and symptoms.
The risks are numerous. Women can falsify their information or withhold information which may mean that these pills are not suitable for them The pills may not be taken properly There is more possibility for problems if the woman has not been seen face to face. Mothers may not have enough counselling to make an informed decision.
With no intention to offend any person my observations led me to believe that the general knowledge of society with regards to the basic medical matters is very low. Many woman do not understand the how menstrual cycle flows, how to implement effective anti-conception, how to properly take abortion pills...sometimes they are unable to say when they got pregnant or even do not remember when their last period was. Many do not read medicine leaflets. I think that they are unaware of potential consequences for their own health if abortion pills are not taken exactly as needed. Also without confidential, in person, one to one appointment with NHS staff they could be prone to other peoples pressures to take the abortion pills. I do not think that the risk of medicine misuse can be mitigated without in person appointment.
Carrying out an abortion at home is not straightforward and there are specific dangers for women, including: • Taking the abortion pills at the “wrong gestation”. Abortion pills are designed to be taken up to ten weeks of pregnancy, as they are less effective, and more harmful for the woman, when taken later in gestation. In one UK study more than 50% of women having abortions after 13 weeks needed subsequent surgical intervention. • Not adhering to the precise time intervals between the two stages of the abortion. The timing between taking Mifepristone (the first pill) and taking Misoprostol (the second dose) is critically important. Taking the second dose incorrectly increases complications for the woman and she may require surgery. As many as half of all recommended protocols for prescription drug use are not followed, or not followed correctly. • Generally taking the drugs incorrectly. As many as half all recommended protocols for prescription drug use are not followed, or not followed correctly.16 For Mifepristone/Misoprostol this is a particular problem, because more than for most drugs, its recommended protocol is fairly precise, and departure from it will increase the rate of incomplete abortion, with its attendant harm to women.
I believe there would be a number of risks associated with the temporary measure. Some women may have preferred to visit the hospital for this procedure for support (emotional, physical and pyshcological) and perhaps to escape from something in their home environment where they wouldn't feel comfortable in going ahead with the procedure. Also, by not seeing a healthcare professional in person may result in safeguarding issues not being picked up on. Another risk may be, someone potentially being bribed into getting this medication and then taking it home and it being given to someone else. This could potentially increase the risk of women/girls being forced into sex without consent, and being made to take the pills without heath care professionals seeing them in person to pick up on safeguarding issues.

One risk could be that women may ask for this medication and they could actually be further along the pregnancy than the 10 week window. Another risk could be that if there were complications with the procedure then the women are at home, whereas if the procedure was in the hospital they have the medical support readily available.
These would relate to the calculation of gestation, the precision of administration and timing of the doses, and emotional distress. Given the remote nature of the process, I do not think these can be effectively mitigated.
Very few
There is some risk with ensuring accuracy of gestational dates, although ensuring that women in any doubt are seen in clinic can mitigate this risk. Provision of good information (e.g. about where to go in the event of medical complications) also referral to counselling if required after the telephone consultation as per good practice.
Risk to mother's health. Risk of coercion. Lack of medical supervision.
Risks to women having an abortion without proper assessment, not even a physical exam to make sure that the stage of pregnancy is suitable for the method, Risks to the mental health as well as the above for women who have abusive partners Risks to children living in the home where the abortion happens, I found it scary and messy when I spontaneously aborted and I was in too much pain to have noticed what was going on around me. While this isn't everyone's experience I'm not the only one who has experienced this. A way to mitigate this would be to make sure that everyone involved is educated to know what to expect, a very good way to do this would be to watch the film 'Unplanned', it only takes 90 mins and it gives a clear, helpful, sensitive, real-life story of a lady who had 3 early abortions. I wonder it isn't shown in schools as part of RSE. It is rated 15. It should certainly be a necessary part of training for all healthworkers who are likely to deal with pregnancy.
No risk
There is bound to be a risk in reducing the need for consultation and consideration, i.e. that abortion becomes more 'routine' and thoughtless. It will also be difficult to ensure that all women receiving pills are doing so freely, without coercion.
In rare cases the risks might me a missed ectopic or molar pregnancy but, with a thorough assessment before treatment this can be hopefully eliminated, we provide low sensitivity pregnancy tests for all women/girls to do two weeks post treatment and concise verbal and written information is given to all women/girls. There is the risk that women do not use the medication or decided to use the medicines at a later date but, women have to take some responsibility and if the medication is not used advice is given. If women/girls contact us with concerns, we will always follow-up at clinic and an ultrasound if required. There is also a risk of medications being taken by an abusive partner but, again a thorough triage or further information from safeguarding before treatment should be gained.
Women could be being forced into an abortion and so without any help from another person in a consultation are even more at risk of having the abortion against their will.
The provision of abortion without an in-person appointment increases the potential for harm to women at risk of coercion. Without a mandatory in-person appointment it will be difficult to ensure that all women receiving pills are doing so freely, without coercion. In such a critical decision where a life or more than one life is involved this does not seem appropriate.
I do not consider there to be any risks.
Thousands of women in Wales have been able to access care that otherwise they may have struggled to obtain. Around 60,000 women have received telemedical abortion care across Great Britain since the original approval, with no notable difference to the already low risk profile of abortion care.
So long as adequate explanations are given as to how to follow the procedures, I do not see that there are any risks.
Consent. Women may be influenced by others to make the decision and staff can't completely understand if they are alone when giving consent. Possibly an assessment made in advance of the patient's vulnerability on a case by case basis. Prioritise those patients that need face to face.
Although no healthcare is risk-free, abortion is a low risk procedure which in all instances is safer than continuing a pregnancy to term • Abortion providers across Wales and Great Britain have worked hard to establish a safe, effective, and accessible telemedical abortion model at a time when all other healthcare has been under substantial pressure. This has meant thousands of women in Wales have been able to access care that otherwise they may have struggled to obtain. • This consultation is rightly only concerned with where the first part of an Early Medical Abortion is taken. Decisions to scan women only where indicated, and how doctors and nurses undertake clinical consultations are based on best medical practice and clinical guidelines – not on government approval. Guidance that routine scanning is not necessary to provide a safe and effective abortion service has been in place since 2011 in RCOG's Guidance for the Care of Women Requesting Induced Abortion. • Around 60,000 women have received telemedical abortion care across Great Britain since the original approval, with no notable difference to the already low risk profile of abortion care.
Only if people do not have access to computers or phones, or are not comfortable using them. For those people, a physical service should still exist.
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I believe that there are very little risks which can be associated with these measures as it is already proven that early abortions such as the ones being discussed within these measures, pose very little risks to the mother meaning the procedure can be carried out safely at home with little to no medical assistance.
Risks can be mitigated, ensuring women have the right to access these services are crucial especially for those who are affected by domestic violence.
None
There is a clear danger of women being coerced into abortions that they do not want, for instance by an abusive partner or domineering parents. The risks can be mitigated by requiring confidential, in-person interviews with appropriate health personnel.
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Manageable risks as there can be with any medication
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Initially I was concerned about picking up cases that need extra support with regards to safeguardfing. It has been the case in our service that close links with Sexual Health and the remote and online nature of the services have translated into more safeguarding cases being supported by an MDT.
I feel that that as patients are not being seen in a clinical setting for first consultation, they are not being scanned to rule out the possibility of Etopic pregnancies and ensuring that the pregnancy is no further than 9weeks and 6 days. these In my eyes are essential first line medical examinations prior to administering medication.

women are also missing out on the personal and emotionally care that should be delivered to them in this very stressful situation, which could result in mental health concerns for the patient involved. Further risks could involve the patient not taking the Misoprostol correctly - 4 tablets which are to be taken buccally and left to dissolve for 30 mins 36-48 hours following Mifepristone. if these are not taken properly then there is a high risk of a failed medical termination, however as patient are likely to bleed following taking the mifepristone then they may not be aware of a failed termination, and the pregnancy could continue without the patient realising. especially as no follow up clinic appointment is now required for patient to be rescanned. I am also concerned by the fact that patient have to have access to a telephone and transport, and also have a support person to stay with them. however unfortunately many people do not have easy access to these, therefore leaving them at a high risk of being isolated when they may require medical help.
There are significant risks, as there is no clear visibility of the woman's actual situation and any ""back-story"" or pressures on her to go ahead with an act she is not sure of, can more easily remain hidden. The provision of abortion without an in-person appointment increases the potential for harm to women at risk of coercion. Without a mandatory in-person appointment it will be difficult to ensure that all women receiving pills are doing so freely, without coercion. I understand that it is widely accepted that women seeking abortion are more likely to have experienced some form of abuse than women seeking antenatal care. It is essential that abortion services have robust safeguarding procedures in place, and it is unclear how this could be achieved via telemedicine. The scope for coercion is widened. It is difficult to see how appropriate safeguarding can be provided this way, particularly where there is domestic abuse involved and the woman therefore is not free to express her true feelings and position.
• Although no healthcare is risk-free, abortion is a low risk procedure which in all instances is safer than continuing a pregnancy to term • Abortion providers across Wales and Great Britain have worked hard to establish a safe, effective, and accessible telemedical abortion model at a time when all other healthcare has been under substantial pressure. This has meant thousands of women in Wales have been able to access care that otherwise they may have struggled to obtain. • This consultation is rightly only concerned with where the first part of an Early Medical Abortion is taken. Decisions to scan women only where indicated, and how doctors and nurses undertake clinical consultations are based on best medical practice and clinical guidelines – not on government approval. Guidance that routine scanning is not necessary to provide a safe and effective abortion service has been in place since 2011 in RCOG's Guidance for the Care of Women Requesting Induced Abortion. • Around 60,000 women have received telemedical abortion care across Great Britain since the original approval, with no notable difference to the already low risk profile of abortion care.
I think there could be potential harm to women who are at risk of coercion. I think there is an immense need for an in-person appointment in order to ensure safety of these women, or potential coercion will not be noticed.
As stated in question 1 above I am concerned that the professional's objectivity that comes from face to face meetings may be impaired by dealing at a distance. Also reading body language is difficult to say the least if the person coming for advice is not in the same room. There is also the risk that women may be under undue third party pressure to proceed with an abortion.
Without in person appointments there is a greater risk of coercion.Women could be pressured more easily into making a decision a decision that they themselves are not happy with.
A decision that a woman has to make regarding an abortion is of great importance and it is essential that she does this of her own free will. It is essential that she has professional face to face advice and is properly advised of both physical and mental risks associated with abortion.
There is a great risk of co-ercion if the woman involved does not have a mandatory face-to-face appointment with a medical professional. Without this there is a great danger that she might be forced into the wrong decision against her will and consequently have to live with a life-time of regret.
Women seeking an abortion are in a vulnerable position, some are also in a very dangerous situation where they may have been raped or abused. Whilst the medical profession are not in the position to protect women in these situations, they may be the first people who become aware of abuse or rape and then able to refer the women on to other services for help and support. When women are seeking help over the telephone, doctors are unable to fully assess the state of mind of the person they are dealing with, or indeed, if the woman is being coerced into this decision. These risks are mitigated when women seeking abortion have an appointment in person with a doctor - on their own, with no other adult present. Whilst not all may not open up about their situation even then, many will and it is more likely that a doctor will be able to sense if there are underlying concerns and be able to assess the situation more fully.
Risks to women carrying out an abortion under the temporary measures include: • Taking the abortion pills at the "wrong gestation". Abortion pills are designed to be taken up to ten weeks of pregnancy, as they are less effective, and more harmful for the woman, when taken later in gestation. In one UK study more than 50% of women having abortions after 13 weeks needed subsequent surgical intervention. • Not adhering to the precise time intervals between the two stages of the abortion. The timing between taking Mifepristone (the first pill) and taking Misoprostol (the second dose) is critically important. Taking the second dose incorrectly increases complications for the woman and she may require surgery. As many as half of all recommended protocols for prescription drug use are not followed, or not followed correctly. • Emotional distress. Carrying out an abortion under the temporary measures at home is a painful and traumatic experience for women, who are often alone. Many studies show that women experience emotional distress after an abortion and other studies show mental health problems for women after abortion. Home abortions may lead to more

adverse psychological consequences, in part because a woman may be alone when she aborts and may also see the foetus who is expelled.
Risk of coercion
The provision of abortion without an in-person appointment increases the potential for harm to women at risk of coercion. Without a mandatory in-person appointment it will be difficult to ensure that all women receiving pills are doing so freely, without coercion.
I feel its dangerous, this is purely as I've stated, you dont know what individual is access this, If its actually for them and if they are doing it for the right reason. By seeing a person your able to assess body language maturity and understanding which your unable to do over the phone. Some ladies don't understand the complications that can occur from such medication and half the time end up in hospital either way.
May be coercion in a relationship but that risk is there anyway
I don't know about the physical risk well enough to comment, apart from realising there must be one as with all medical procedure such as taking medication. However, the risk to the mental health of the patient is higher that most want to acknowledge. There is also the real risk of coercion. Without a mandatory in-person appointment it's clearly more difficult to ensure that all women receiving pills are doing so freely, without coercion.
As abortion is a low risk procedure, and as complications reduce the earlier it is undertaken, making this as simple as possible should be the goal for all concerned. There are still procedures in place for scanning or further consultation should they be deemed necessary by either the women or the consultants.
Data suggests that in fact the temporary measure has not increased risk over its duration.
The only risk is the word 'temporary' meaning this excellent option may no longer be available soon. Initial concern regarding effective safeguarding has been disproved. Women speak more openly and esp during video Consulting the clinicians are able to notice possible problems. Further initial concern about managing early pregnancy pathology has been disproven. Clinical pathways ensure identification of risk and good follow-up via call/email/text . There is no additional risk of late diagnosis of abnormal pregnancy with telemedicine in abortion care.
Abortion is a dangerous procedure and remote provision of abortion drugs without an in-person appointment increases the potential for harm to women physically emotionally with perhaps no one to help or support her through the horrible effects of the drugs. It also puts her at risk of coercion. Without a mandatory in-person appointment it will be difficult to ensure that all women receiving pills are doing so freely, without coercion.
As I said earlier, a simplification of this service simply gives women greater control over their own bodies and their lives. There is nothing risky about that. These practitioners are trained to be sensitive to potentially abusive situations, and women who may have been coerced, but this is always a risk.
The risk is that the pressure of other people including violence,can be huge,at a time when women are highly susceptible to the influence of those around them. There needs to be the input of a professional medical voice.
Abortion, while not entirely without risk, constitutes a lower risk than of carrying a pregnancy to term. I understand approximately 60000 abortions have been carried out using this new delivery model and no increased risks have been noted. Indeed, complications have reduced.
-
No measurable additional risk.
I don't know of risks.
To ensure suitable choices are made women need appropriate and timely information and advice with patient centred care.
Home abortion is a traumatic experience which should not be carried out alone at home.
The provision of abortion without an in-person appointment increases the potential for harm to women at risk of coercion. Without a mandatory in-person appointment it will be difficult to ensure that all women receiving pills are doing so freely, without coercion.
An abortion without an in person appointment will increase the potential for harm to women who may be at risk of coercion from the family, a partner or others. Without a mandatory in person appointment it will be difficult to make sure that all women receiving pills are doing so of their own free will, without coercion.
Dim risgiau.
Increased safety risks in physical health for women who have complications at home, increased risks for the mental health of women who have an abortion at home and have to deal with the abortion physically in terms of disposing of the aborted foetus and also not having access to the support necessary after they have an abortion. With the whole process being dealt with at home and possible making it easier to access an abortion then abortions could be accessed at a time when it is not medically safe for women or legally within the law. However, it also limits a woman’s access to the necessary support services after she has an abortion. Younger girls could access abortion services without adequate checks. Women may feel pressurised into abortions by abusive partners and this risk cannot be assessed in telephone consultations.
Taking pills at the wrong gestation is a great danger, or not taking the two pills at the correct interval.There is a risk of surgical intervention being necessary, with the subsequent danger of sepsis, bleeding, even death. Women are often confused with their dates, either intentionally or otherwise. The trauma of carrying out an abortion at home, maybe alone,is very distressing and painfull. Mental health issues are more likely, studies have shown.

The risks have been apparent in the number of very sad cases of deaths and medical complications among those who have used the DIY abortion measure. It has also led to a mother illegally aborting a 28day old baby. At home abortion increases the risk of coercive abortions and exposes women and children to greater risk of harm, without the help and support of healthcare professionals.
The risks are those associated with the self administration of these potent abortifacients i.e.;- (I) treatment outside the recommended stage of pregnancy - either too early or too late .Taking the ""pill"" too late is more harmful as regards the seriousness of the consequences, which could mean an operation. If taken at an advanced stage of pregnancy, a criminal investigation could result . Mistakes about the stage of pregnancy ,especially when it is an unintended or unwanted pregnancy ,are more likely to occur. Women ""presenting"" at maternity clinics are sometimes surprised to discover that they are at a more advanced stage than they previously thought. (ii) mis-timing of the inter-dose interval - this can also result in serious complications needing surgery. A survey has shown that, under optimal conditions, in <50% of cases where prescription drugs were given,patients failed to follow the instructions and/or complete the course of treatment .That survey was conducted with patients under 'optimal 'conditions - I would suggest that in the case of women seeking an abortion, conditions could not be described as 'optimal'. I think it possible that there could be occasions when a woman having taken the first dose could be having second thoughts about the irrevocable step of the second dose.If she does eventually take a delayed second dose ,perhaps under duress against her will or conscience, or against her better judgement where counselling is inadequate,she would risk potentially serious medical complications Risks to mental health - this risk has been demonstrated by several studies. Women requesting abortions are likely to be suffering from some degree of stress.At the least, a home abortion is going to be an unpleasant experience.I suggest that for some it is a frightening, painful and possibly lonely experience,taking place, maybe in secret with no help present --unless the company be an abusive partner there to make sure things go as he wants. Having to see, handle and dispose of the foetus further adds to the stress. It has been shown that emotional trauma at abortion can lead to mental health problems which can be long lasting and recur in later life . Emotional stress is likely to be greater with a ' DIY ' home abortion than in a clinic or hospital.
There are risk associated and there should be adequate follow up to ensure that the process goes well. Women are given the signs of complications to look out for so they are able to seek medical treatment at the earliest opportunity. It's no more dangerous than having a tooth pulled or tonsils out so why shouldn't women be given the same opportunities to recover at home?
There are risks to women's' health which can only be dealt with be the removal of this measure.
Eliminating responsibility
If a woman is certified to have an abortion without seeing a physician, isn't she at greater risk of experiencing an ectopic pregnancy or becoming infertile? Would vulnerable young women be as likely to get measured and sound advice or be encouraged to think about the consequences on their mental health? Mitigation of these risks would simply mean seeing someone in person.
Providers cannot confirm the eligibility of a woman for early medical abortion at home. This has been clearly confirmed through Christian concern Mystery Client Investigation, which found that in all cases, women were able to obtain the pills by providing false information. Providers cannot confirm that it would be safe for the woman to have early medical abortion. Providers are unable to carry out a scan with telemedicine. A scan could reveal issues with the pregnancy which mean that the pills would be unsafe to take. Providers cannot confirm the identity of the woman requesting abortion pills. Complications in the pregnancy could be missed due to lack of scans and proper checks that would otherwise be done in clinic, eg. ectopic pregnancy. Providers are not able to confirm the gestational age of the pregnancy. Women could be given the pills even if the pregnancy is over 10 weeks' gestation. There is too great an ease of access and too much dependency on the woman to be sure of gestational age. Providers are unable to check that the woman is not being coerced. There is not a safe, private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure from an abusive partner or parent. Women should be given full information about the risks of abortion carried out at any gestation and under any circumstances, but especially about the risks of taking the pills after 10 weeks.
the ruination of young people by letting them (even encouraging them) to have sexual intercourse is simply wrong and should be opposed by those who care for safeguarding the next generation.
Powerful drugs are being sent through the post with no way of knowing who will take them. There is no way of knowing at which point in the pregnancy the drugs are being taken – as seen with one woman found to have aborted her baby at 28 weeks.
In hospitals drugs are administered to the right patient, at the right time and at the right dosage. Home delivery of such strong drugs cannot guarantee that the right person has the drug. Neither is there any way of knowing when in the pregnancy the drugs have been taken. So you cannot guarantee the right time Neither can you guarantee where the drug will be taken. It could even be taken at a school, not the home. I even consider the women to be at risk if she is not first seen by a doctor . So the risks cannot be mitigated.
Providers cannot confirm the eligibility of a woman for early medical abortion at home. This has been clearly confirmed through our Mystery Client Investigation, which found that in all cases, women were able to obtain the pills

by providing false information.
Providers cannot confirm that it would be safe for the woman to have early medical abortion. Providers are unable to carry out a scan with telemedicine. A scan could reveal issues with the pregnancy which mean that the pills would be unsafe to take.
Providers cannot confirm the identity of the woman requesting abortion pills.
Complications in the pregnancy could be missed due to lack of scans and proper checks that would otherwise be done in clinic, eg. ectopic pregnancy.
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Providers are unable to check that the woman is not being coerced. There is not a safe, private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure from an abusive partner or parent.
Women should be given full information about the risks of abortion carried out at any gestation and under any circumstances, but especially about the risks of taking the pills after 10 weeks.

Women are not safely vetted for their mental health risks adequately and the decision to abort.
A thorough understanding of the processes of the abortion pill.
Safe physical medical examination to check for any issues that may be present that do not warrant an abortion.
Appropriate and adequate follow up physically.

It's crazy that these potent medicines are just being posted out to people, who knows who will take them?

My wife just suffered an 8-week miscarriage, she went through an extremely high amount of bleeding which was traumatic to deal with at home to say the least. To encourage such an event to take place at home seems unthinkable and dangerous.

Providers cannot confirm the eligibility of a woman for early medical abortion at home. This has been clearly confirmed through a Mystery Client Investigation, which found that in all cases, women were able to obtain the pills by providing false information.

Providers cannot confirm that it would be safe for the woman to have early medical abortion.
Providers are unable to carry out a scan with telemedicine. A scan could reveal issues with the pregnancy which mean that the pills would be unsafe to take.

Providers cannot confirm the identity of the woman requesting abortion pills.
Complications in the pregnancy could be missed due to lack of scans and proper checks that would otherwise be done in clinic, eg. ectopic pregnancy.

Providers are not able to confirm the gestational age of the pregnancy. Women could be given the pills even if the pregnancy is over 10 weeks' gestation. There is too great an ease of access and too much dependency on the woman to be sure of gestational age.

Providers are unable to check that the woman is not being coerced. There is not a safe, private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure from an abusive partner or parent.
Women should be given full information about the risks of abortion carried out at any gestation and under any circumstances, but especially about the risks of taking the pills after 10 weeks.

Mae cyffuriau cryf iawn yn cael eu danfon drwy'r post heb unrhyw sicrwydd pwy fydd yn eu cymryd neu bwy all gael gafael arnynt. Cafwyd un digwyddiad o wraig yn erthylu ei babi wedi i 28 wythnos fynd heibio!

Yn fy marn gref i rhaid i wir asesiad o'r risgiau cael erthyliad gartref gynnwys y canlyniadau meddyliol a chorfforol o gael erthyliad ar y fam, ac mae'r rhain yn cynnwys pethau fel y risg gynyddol o enedigaethau annhymig sy'n dilyn hyn, y risg uwch o broblemau iechyd meddyliol a chymhlethdodau sy'n deillio o golli gwaed.

Delivering powerful drugs through the post is very risky and is open to exploitation. There is no way of knowing at which point in the pregnancy the drugs are being taken – as seen with one woman found to have aborted her baby at 28 weeks. It is impossible to ensure that abortion pills will be taken at home and not in public places for example, in schools.

Anfonir cyffuriau cryf trwy'r post heb unrhyw ffordd o sicrhau pwy fydd yn eu cymryd na phryd na ble. Nid yw menyw sydd am gael erthyliad yn gweld meddyg ac felly gall hyn beryglu bywydau drwy beidio â adnabod problemau fel beichiogrwydd ectopig. Dylai asesiad o beryglon cael erthyliad yn y tŷ gynnwys y goblygiadau meddyliol a chorfforol i'r fam, megis perygl cael mwy o enedigaethau cynamserol wedyn, perygl cael mwy o broblemau iechyd meddwl a chymhlethdodau fel gwaedlifau.

Women are being certified for abortion without seeing a doctor in person. This increases the risk of potentially life-threatening conditions, such as ectopic pregnancy, being missed.
There is no way these risks can be avoided.

The drugs used are very powerful and by being sent through the post there is no guarantee that they will be taken by the right person, and at the correct time. There have been reports that ladies have taken them past the allowed first ten weeks of pregnancy. There is also the chance that problems such as ectopic pregnancies could be missed.

The great risk is to the mental health of the expectant mother ,who makes a life changing decision often on her own or coerced by the partner .The dangers of the home abortion with excess blood loss for the mother and infections caused by un hygienic surroundings is one reason this provision needs to be stopped .
Only by allowing a medical midwife visit can the risks be reduced ..

The only significant risk I can think of would be if service users wanted some medical guidance around taking the tablets, or the side effects, or about the decision to terminate the pregnancy more generally, and felt unable to access this. It is very important that advice in these areas remains accessible to the service users (including those without internet access).
Taking the abortion pills at the “wrong gestation”. Abortion pills are designed to be taken up to ten weeks of pregnancy, as they are less effective, and more harmful for the woman, when taken later in gestation. In one UK study more than 50% of women having abortions after 13 weeks needed subsequent surgical intervention.4 • Not adhering to the precise time intervals between the two stages of the abortion. The timing between taking Mifepristone (the first pill) and taking Misoprostol (the second dose) is critically important. Taking the second dose incorrectly increases complications for the woman and she may require surgery. As many as half of all recommended protocols for prescription drug use are not followed, or not followed correctly.5 • Emotional distress. Carrying out a DIY abortion at home is a painful and traumatic experience for women, who are often alone. Many studies show that women experience emotional distress after an abortion and other studies show mental health problems for women after abortion. Home abortions may lead to more adverse psychological consequences, in part because a woman may be alone when she aborts and may see the foetus expelled.
The risk of complications from an early medical termination is extremely low. If they were mitigated during covid, which they were, there is absolutely no reason why this would be a reason to withdraw the service. If a pregnant person is high risk they can still opt to attend a clinical setting
Drugs sent through the post are unsupervised and therefore potentially very dangerous. I don't think these risks could be easily mitigated.
Some 3% of women who take abortion pills up to 9 weeks’ gestation will need surgical treatment for an incomplete abortion, according to BPAS. This increases to 7% of women for those whose pregnancy is between 9-10 weeks’ gestation. The abortion provider is not the one managing these complications. Providers cannot confirm the eligibility of a woman for early medical abortion at home. This has been clearly confirmed through our Mystery Client Investigation, which found that in all cases, women were able to obtain the pills by providing false information. Providers cannot confirm that it would be safe for the woman to have early medical abortion. Providers are unable to carry out a scan with telemedicine. A scan could reveal issues with the pregnancy which mean that the pills would be unsafe to take. Providers cannot confirm the identity of the woman requesting abortion pills. Complications in the pregnancy could be missed due to lack of scans and proper checks that would otherwise be done in clinic, eg. ectopic pregnancy. Providers are not able to confirm the gestational age of the pregnancy. Women could be given the pills even if the pregnancy is over 10 weeks’ gestation. There is too great an ease of access and too much dependency on the woman to be sure of gestational age. Providers are unable to check that the woman is not being coerced. There is not a safe, private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure from an abusive partner or parent. Women should be given full information about the risks of abortion carried out at any gestation and under any circumstances, but especially about the risks of taking the pills after 10 weeks.
A proper assessment of the risks of home abortion must include the mental and physical consequences of an abortion for the mother, and I just can't see how that can be carried out with these proposals. Additionally, there is no way to stop a clinician making an incorrect diagnosis on a patient they never see, just as there is no way to treat a haemorrhaging woman you isn't in your building. The prescriber has no way of knowing that the mother is taking the drugs when she should. They could be passed onto anyone. A sexual abuser could obtain the drugs and foist them on a child they have abused and who is now pregnant.
1) Risk of abortion coercion 2) Risk to women's a) physical health b) mental health These risks can only really be addressed by removing the provision of abortions at home.
As outlined in my answer to question 1: (1) the woman's identity cannot be verified, leading to potential abuse of the system; (2) The provider cannot tell if the client is being coerced; (3) Women may take these pills beyond the 10-week limit; (4) women can obtain these pills by providing false information. Added those points: Complications in the pregnancy (i.e. ectopic pregnancy) will be missed without the proper scans.
There are risks IF patients are not accurate with their dates. We stress the importance of this being exact but we cannot guarantee if a patient is being truthful or not. Patients who have attended before know over 10wk gestation

need to be in a hospital setting, there's a potential that people try to mislead intentionally however would be risking their own health in doing so.
As these drugs are being sent through the post, there is no way of confirming exactly who is taking them and under what circumstances. Vulnerable woman may be coerced. Given there is no review in person by a health care professional, other serious medical conditions such as ectopic pregnancies could potentially be missed with life threatening sequelae. Also there is no way of knowing at what stage of the pregnancy the medications are being taken. It has been reported in the national press (23rd May 2020) that a police investigation was prompted when a woman was found to have taken the medications by post at 28 weeks.
Lack of support and advice for woman. Long term impact on their welfare not considered.,
There may be the risk of service users not having full compliance or understanding of drug interactions or means to use the drugs. This could be supported with a leaflet being sent via text or email, which ever the service user feels more comfortable with, enabling visual pictures, diagrams and written information to further support the information passed on through conversation. The leaflet could also highlight common side effects, cautions, what to expect, when to attend the hospital for medical reasons. Terminations also carry increased rates of depression and anxiety following, therefore, service users should be shown services and health professional contacts whom they could contact should they develop concerns with psychological health.
The greatest risk is surely that of facilitating a rush to terminate unborn life without adequate consultation, as well as the associated potential risks to the physical and mental health of the mother. Women need the advice of experienced clinicians as well as of pastors and social workers before making such a momentous decision.
There is the clear risk of pills not being taken by the individual but by another, or being taken at the wrong time or at a far later stage of pregnancy. There is also the risk that complications during the abortion process aren't flagged up, because both pills are taken without being seen by a clinician.
Yes. Gestational age is much harder to ascertain under the current measures and this makes the risk of taking the pills when they would be more dangerous much higher. The second dose is more likely to be taken at the wrong time, increasing the risk of complications. The risk of the pills ending up in the hands of abusers is also greatly increased. I do not see how these risks can be mitigated sufficiently to justify these measures.
There is the risk that women will be pressured to have an abortion, against their will, from a husband or boyfriend. Also, women may not know exactly how many weeks of gestation have taken place.
I have concerns about the misuse of the service, whereby women claim to be in early pregnancy but in fact are much later in pregnancy. It is very difficult to verify that the duration of the gestation of a woman's pregnancy is not beyond 12 weeks (when the uterus becomes palpable) without a clinic assessment. Late EMAH are likely to increase the risks to the mother. A mandatory ultrasound or clinic assessment should eliminate late EMAH. I also have concerns about coercive partners forcing EMAH on pregnant women which is also going to be harder to pick up without a clinic assessment. A sensitive clinic assessment would be more likely pick up on women being forced into EMAH aginst their will. TOP is associated with adverse mental health problems, and these may be exacerbated by EMAH where the woman has to dispose of foetal material.
There is high risk of complications with each day of pregnancy. I do not think that telephone consultations are adequate to properly assess the women. There is lack of counselling about abortion regret. These concerns cannot be mitigated.
It has been given established that at least one woman has died from excess bleeding. These risks can only be mitigated by a face to face consultation done in a steady and professional way, do that possible side effects are fully discussed.
Around 60,000women have received telemedical abortion care across GB since the original approval, with no notable difference to the already low risk of receiving abortion care.
Inaccurate information - relying on mother's knowledge of last period, not having an ultrasound Easier for women who don't want to have an abortion to be forced into it by others (husbands, boyfriends, family, friends etc.)
no risks if it was stopped!!
Women are (and have been demonstrated in tests) able to procure the pills through providing false information, thus eligibility and identity cannot be confirmed. Remote medecine cannot view the whole person and judge whether this process is appropriate. Complications, such as ectopic pregnancies, won't be picked up. Coercion of the women won't be spotted.
It trivialises further the decision making process leading to abortion. It provides a way for those who care nothing for the 9 week restriction to try and abort during later term pregnancies. It makes it easy for women to be subject to pressures from partners/abusers/family members, potentially lurking in the same room, and they don't get to see anyone in person.
Providers cannot confirm the eligibility of the women for early medical abortion. This has been tested by Mystery Clients giving false information. Scans cannot be conducted by telephone! There may be reasons why it would be unsafe to take the pills at home without personal care. Gestational age cannot be checked.

Coercion my be behind the request. Women should be given the full information concerning the risks that abortion cold have on the women..
Powerful drugs are being sent thought he post and you do not know whose hands they may end up in. A true assessment of home abortions must include the physical and mental consequences of an abortion for the mother. Thes include higher risk of future premature births, higher risk of mental health issues, and complications such as haemorrhaging.
It is impossible to ensure that the drugs are taken in the safety of a home environment and could be used in school or outdoors, which would exacerbate any possible complications. There cannot be any check on the actual point of the pregnancy, so that a mother may be much further along in the pregnancy than the recommended 10 weeks. The long term effects on the mother of having an abortion should be discussed with her.
An obvious risk is that DIY abortion could become permanent if not abolished soon. In the meantime, potential risks for women remain, such as taking the pills Mifepristone and Misoprostol incorrectly, emotional distress at seeing the expelled baby and disposing of it, etc. Hopefully all the negative results of DIY abortion, if honestly acknowledged, will come to light before long.
I am concerned that over the phone, women will be able to get abortion medication (mifepristone) at a later gestation age, that they will rarely have ultrasound scans arranged to check gestation or ectopic pregnancy. I am also concerned about the risk of some women being coerced to arrange an abortion (e.g. if there is abuse at home) or provide false identity information over the phone.
1. The risk to women's health of pills being ordered for use by someone else. For example, an abuser could get an older female relative to order pills to be taken by a child victim of sexual abuse. Or someone for whom the pills would not be safe, due to their state of health, could get a friend to order them for her. 2. The risk of abuse if pills being ordered under duress from an abuser, by a woman who does not actually want to take them. 3. The risk of fraud of pills being ordered by a woman who then sells them on, for example in another country. Abortion is a money-saving procedure for many women, and is different in this way from medical treatments to cure illnesses. 4. The risk to women's health of pills being ordered, and then stored to be used later, without any medical knowledge or supervision. These risks cannot be mitigated adequately without face to face contact.
The risks to the mother are real and significant, namely pain, haemorrhage, infection and coercion by partners or family. These could be dealt with to a great extent by banning this irresponsible and harmful practice.
Providers cannot confirm the eligibility of a woman for early medical abortion at home. This has been clearly confirmed through our Mystery Client Investigation, which found that in all cases, women were able to obtain the pills by providing false information. Providers cannot confirm that it would be safe for the woman to have early medical abortion. Providers are unable to carry out a scan with telemedicine. A scan could reveal issues with the pregnancy which mean that the pills would be unsafe to take. Providers cannot confirm the identity of the woman requesting abortion pills. Complications in the pregnancy could be missed due to lack of scans and proper checks that would otherwise be done in clinic, eg. ectopic pregnancy. Providers are not able to confirm the gestational age of the pregnancy. Women could be given the pills even if the pregnancy is over 10 weeks' gestation. There is too great an ease of access and too much dependency on the woman to be sure of gestational age. Providers are unable to check that the woman is not being coerced. There is not a safe, private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure from an abusive partner or parent. Women should be given full information about the risks of abortion carried out at any gestation and under any circumstances, but especially about the risks of taking the pills after 10 weeks.
As well as the risks already mentioned in questions one and two a major problem is that it leaves women much more vulnerable to coercion whether this is from family or partner. There is already research which demonstrates that it is not unusual for coercion to have taken place in cases of abortion. This legislation will mean that the few safeguards that are in place and the opportunity for a woman to bring up coercion in a private and safe space will be fully removed.
I find it extremely concerning that these powerful drugs are being sent through the postal system and with absolutely no checks to ensure who has used them. It is impossible to ensure that the drugs are being used correctly and that the person having the abortion has not been forced into it against her will. A proper assessment of the risks surely needs to include the consequences for the woman, both mental and physical as abortion can lead to premature births in the future, bleeding and mental health problems.
Women being coerced into a decision they may be uncertain about or actually not wanting to take, without the safeguard of a face-to-face appointment with someone she can safely discuss her situation with, or who may be able to pick up on body language etc re coercion. Unmonitored complications physically/medically, with a woman possibly having to face this alone without support and possibly not having had sufficient preparation. The possibility of not self-administering properly.

I don't see how they can be. A woman asking for an abortion should be advised by a doctor or other suitable health professional so that she understands the implications of the process and any health issues can be identified. Also if she is being coerced into seeking abortion, she should be helped and perhaps signposted towards sources of support.
careful screening of those appropriate and clear safety netting
There are no risks.
Women taking these drugs at home is clearly increasing the risks of lack of assistance should an emergency or complications arise.
I don not feel that there are any increased risks related with this process. In fact all elements of service delivery are more robust. Previously patients had to see many different health professionals all in the context of one episode of care. Now the care is mainly provided by one professional , legal requirements and medical checks are undertaken before attendance so those at increased risk are identified and have management plans developed before their attendance
The EMA taken outside the designated is much more harmful - a huge risk for young women or those without a supportive home particularly where there is no secure relationship.
I'm not a medical person so can't properly assess risk.
Many women have made the decision to have an abortion in the past and lived to regret that decision which in some cases has caused them enormous emotional / psychological upset for many years. To make it mandatory for a face to face appointment so that all the issues have been discussed and there is no possibility of coercion from another person increases that potential for long term harm.
The risks are that the women are not being monitored. For how long has this medication be tested. I think we put women's mental and physical health at risk. I am totally against killing a life with just a pill that has been prescribed over the telephone.
Providers are not able to confirm the gestational age of the pregnancy. Women could be given the pills even if the pregnancy is over 10 weeks' gestation. There is too much ease of access and too much dependency on the woman to be sure of gestational age. Providers are unable to check that the woman is not being coerced. Women suffering domestic abuse are, by definition, very unlikely to be able to safely respond to such consultations. Also, if a woman had a difficult experience of an abortion, she may well not feel able to respond to a questionnaire about this experience just after it. Sexual abuse can be covered up by home abortion. Women should be given full information about the risks of abortion carried being out anyway, but more especially about the risks of taking the pills after 10 weeks of gestation.
Few risks which can be easily mitigated by good assessment
There are risks some of which I have already answered in my previous responses namely not knowing who is actually receiving the pills, not knowing the gestational age of the fetus, not knowing the vulnerability of the client. Also there is no assessment of the women's mental wellbeing. As you may well know 70% of communication is non-verbal. The pills are issued on the basis of a phone call i.e only verbal communication. With no face-to-face interaction women who are in a mentally vulnerable state and need support and counselling are not able to be identified. The US Supreme court has already "reinstated federal rules that require the abortion pill Mifeprex to be dispensed in person by a qualified healthcare provider" (https://www.christian.org.uk/news/us-supreme-court-ends-postal-diy-abortion-pill-service/).
There is good data from other countries of the safety and efficacy of telemedicine. The major theoretical risk is that women will lie about the length of the pregnancy. in my experience as a retired gynaecologist who has dealt with at least 10,000 women requesting abortion during my career in four countries in three continents, women are honest with their doctors.
May be
I do not see any risks associated.
Some of the risks have been outlined above, ie higher gestation than 12 weeks; mistaken identity of caller; women under duress; women going through a painful, traumatic experience on their own or with only an abusive partner present. Also lack of privacy and confidentiality leading to women unable to speak confidentially on the call without an abuser or coercive family member hearing. Missing an opportunity to detect domestic abuse. Medical complications are excessive pain and bleeding, retained products of conception, trauma and emotional distress. Missing an ectopic pregnancy. Missing mental health issues. Not adhering to precise time intervals between the 2 stages of the abortion. Complications are 4 times higher than clinic abortions. Only face to face consultations and medically supervised procedures will mitigate the risks.
It can't be established whether an applicant is elegible - they might give a false ID or other false information. It's unsafe without a scan. What if there is an ectopic pregnancy?
Risks could be people not knowing the exact gestation of the unborn foetus. A clinician providing a telephone consultation does not confirm the date of the last menstrual cycle. It is therefore relying solely on the patient providing the accurate and truthful dates. Having an ultrasound before dispensing the medication to women should be essential ensure that the correct treatment option is given. Having a lack of physical face to face assessment could have an impact on some women's/girls choices. A telephone call can sometimes be impersonal and therefore the clinical is unable to read body language and therefore

it may be harder for a woman to open up. It is impossible to tell if a woman is at risk of being coerced into an EMA from a telephone conversation. It is impossible to know if a woman is alone during the consultation. Unable to ask if the woman is suffering domestic abuse over the telephone as it is not known if anyone else is listening to the conversation. An abuser could be forcing woman to say certain things over the phone. Another risk that I feel is that it there is a responsible adult at home available during the process. If the woman becomes ill or has a large blood loss it is not guaranteed that there is somebody at home who could respond and act upon this immediately, unlike in clinic/ hospital setting.
There are risks of harm to the woman through unforeseen complications due to the abortion; aborting a baby is killing a living human; there are risks of emotional harm to the woman involved; risks of using the medication outside of the guided time limits and significant risk that those suffering domestic abuse will be forced to abort their children. There is also a risk of this medication being used to cover up serious crimes such as child abuse.
The risks associated with this arrangement are huge. No one is monitoring the receipt and administration of the drugs. Powerful drugs like this should not be merely sent in the post where they might be taken by children or other vulnerable people.
The risks are that a woman is offered Early Medical Abortion inappropriately over the time parameters, that an ectopic pregnancy is missed or that she has a complication passing a pregnancy. These have been mitigated through implementing a well-constructed assessment with comprehensive guidance and safety-netting for women, and by identifying and scanning women who are unclear about the date of their last menstrual period. A structure of effective and open case review will enable lessons to be learned and practice to be strengthened.
Providers cannot confirm the eligibility of a woman for early medical abortion at home. This has been clearly confirmed through our Mystery Client Investigation, which found that in all cases, women were able to obtain the pills by providing false information. Providers cannot confirm that it would be safe for the woman to have early medical abortion. Providers are unable to carry out a scan with telemedicine. A scan could reveal issues with the pregnancy which mean that the pills would be unsafe to take. Providers cannot confirm the identity of the woman requesting abortion pills. Complications in the pregnancy could be missed due to lack of scans and proper checks that would otherwise be done in clinic, eg. ectopic pregnancy. Providers are not able to confirm the gestational age of the pregnancy. Women could be given the pills even if the pregnancy is over 10 weeks' gestation. There is too great an ease of access and too much dependency on the woman to be sure of gestational age. Providers are unable to check that the woman is not being coerced. There is not a safe, private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure from an abusive partner or parent. Women should be given full information about the risks of abortion carried out at any gestation and under any circumstances, but especially about the risks of taking the pills after 10 weeks.
Without seeing a doctor important conditions can be easily missed causing wrong diagnosis and danger to the patient. Drugs being sent through the post can be easily lost or misplaced. No proper patient assessment of the after effects is taken i.e. mental health
At Her Voice, we believe one of the most serious risks of the current arrangements for early medical abortion at home (put in place due to Covid-19) is to women's mental health. Many of the women who have shared with Her Voice have suffered as the result of an abortion. We believe this will only be magnified if women are expected to carry out abortions themselves, and deal with the consequences, in their own homes. Allison, who had a surgical termination, said of her experience: "I couldn't stand these feelings. They were so painful. I felt alone, isolated and ostracised… To anaesthetise the pain, I abused alcohol and had many abusive relationships. I was addicted to alcohol for 17 years." You can read Allison's story here: https://www.hervoice.org.uk/allisons-voice.html Nathalie, who had a medical termination in a clinic, said of her experience: "My life then spiralled, as I could not live with the fact that I chose to end my child's life out of fear. I was hospitalised due to severe depression and anxiety exactly a year after my abortion. I also tried to end my life." You can read Nathalie's story here: https://www.hervoice.org.uk/womens-voices/nathalies-voice These women's experiences are not isolated incidents. The mental health of many women suffers as the result of an abortion. This will only worsen if women are expected to carry out their own abortions at home, without any support. Their suffering may also be exacerbated by the fact that they have to deal with the immediate consequences of the abortion, which may include seeing the expelled foetus and having to dispose of it. We should not put the entirety of the physical and emotional weight of medical terminations on women by allowing for early medical terminations at home.
Risks of serious complications which may go in noticed. Risk of rash decisions that are then regretted.
Providers can't confirm the eligibility of a woman for early medical abortion at home. The most mystery client proved this.

Providers can't confirm it would be safe for a woman to have an early medical abortion. They need to carry out a scan. A scan could reveal issues with the pregnancy which would mean pills were unsafe to take.
Providers can't confirm the the identity of a woman.
Providers can't confirm the the gestational age of the pregnancy. Women could be given pills even if the pregnancy is 10 weeks over gestation. It is too easy to access the pills and there is too much dependency on the woman to be sure of her gestational age.
Providers are unable to check the woman is not being coerced. There is no safe, private space for a woman to talk freely about whether she wants an abortion or is doing so under pressure from an abusive partner or parent.
Women should be given full information about the risks of abortion carried out at any gestational age and under any circumstances, but especially about the risks or taking any pills after 10 weeks.

There is no way of knowing who will be taking these powerful drugs that are being sent by post. Nor is it known at what stage in the pregnancy they are being taken. The drugs may be taken elsewhere than at home, eg school and there could be pressure and abuse.
As women are not being actually seen by a doctor there is increased risk of life threatening conditions such as ectopic pregnancy, being missed.

Women are allowed to abort without seeing a doctor which increases the risk of conditions such ectopic pregnancy not being seen.

I feel the potential negatives far outweigh potential positives alluded to in the consultation. Powerful drugs are being sent through the post and there is no way of knowing at what point in a pregnancy these drugs are being taken. A woman has already been found to have taken a pill when 28 weeks pregnant.
Also, a true risk assessment of this temporary measure must take into account both the physical and mental health of women. It is far too early to draw viable conclusions.
Finally, my last point is that this could lead to young girls taking these drugs, even at school, leaving them open to abuse of the system and coercion.

1. Incorrect assessment of gestational age, as self-assessment of LMP is notoriously prone to error.
2. Incorrect assessment of medical eligibility, as the prescriber is entirely reliant on self-reported history, without confirmatory clinical examination.
3. 'Remote' consultation is open to deception of the provider, if there is intention to cause this.
4. Lack of 'in person' consultation reduces the possibility of detection of domestic abuse, which is a recognised concern in a sub-set of the population of women seeking abortion.
5. 'Remote' consultation can allow coercion in the procurement of abortion as there is no 'safe space' in which the provider can investigate this possibility.
6. The potential speed with which medication can be provided may become a source of regret if there has been insufficient time to consider the decision, and without the opportunity for discussion with a trained counsellor.

There is no substitute for appropriate clinical assessment and examination, and access to confidential counselling if needed.

As a teacher I am concerned about how these drugs can be used by vulnerable young people and the lack of protections against coercion into taking them. It is difficult to imagine how this can be protected if DIY abortions are allowed to continue. This policy gives little or no consideration to the mental well-being of the mother.

- powerful drugs being sent through the post
- guaranteeing that the correct person takes these drugs, false NHS numbers could be used
- guaranteeing that the mother has the correct gestational age
- complications in mothers health being missed

Do you know who is receiving these medications? Have they been verified as being pregnant? Would these drugs be handed to a friend who could be as young as 11 years of age perhaps? Do you know what the time of gestation is? What are the risks to the mental health of the recipient? What if they should haemorrhage? These risks can only be mitigated by someone professional being there - not the person doing this at home.

With these abortion pills being sent by post, how can this scheme guarantee that the person taking the pill is emotionally and mentally prepared for the trauma they may face. Have all the options been discussed with the individual? How can it be guaranteed that minors (those still in school) have not gotten their hands on these pills either through coercion or abuse.

Risks associated with taking the pills over 10 weeks gestation

As mentioned above, there are particular risks with women taking the pills past 10 weeks.

• Abortion pills are designed to be taken up to ten weeks of pregnancy, as they are less effective, and more harmful for the woman, when taken later in gestation. Many pregnant women do not know their gestation until they have a dating scan. When women guess, they tend to underestimate their gestation. 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 (https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/05/methods-for-estimating-the-due-date). Studies report that approximately one half of women do not accurately recall their LMP. The consequences for women misjudging their pregnancy dates could be severe. In one UK study more than 50 per cent of women having abortions after 13 weeks (so only a few weeks' difference) needed subsequent surgical intervention. (https://www.sciencedirect.com/science/article/abs/pii/S0010782497001844)
• The abortion complication rate also increases rapidly with each week of gestation, one study finding a 38% increase for each week (Bartlett LA et al. (2004) Risk factors for legal induced abortion-related mortality in the United States). Recent research shows that 16.3% of women who had medical abortions at 57-63 days and 20.5% of those who had medical abortions at 64-76 days made an unscheduled return visit because of concerns about complications (Larsson A & Ronnberg A-KM (2019) Expanding a woman's options to include home use of

misoprostol for medical abortion up until 76 days: an observational study of efficacy and safety). For 77-100 days the figure rose to 22.5% (Endler M et al. (2018) Safety and acceptability of medical abortion through telemedicine after 9 weeks of gestation: a population-based cohort study. BJOG 126:609–618.)
• Pain for the unborn baby. Some researchers believe that pain sensation may occur before the 10th week of gestation (and possibly as early as the 6-7th weeks), due to maturation of particular neural structures as well as the lack of pain inhibition mechanisms (Sekulic S et al. (2016) Appearance of fetal pain could be associated with maturation of the mesodiencephalic structures. J Pain Res 9:1031-1038).
• By ten weeks, the unborn baby is an inch and a half long, and clearly recognisable. This may cause more distress for women passing the baby alone at home.

Other risks

Not adhering to the precise time intervals between the two stages of the abortion. The timing between taking Mifepristone (the first pill) and taking Misoprostol (the second dose) is critically important. Taking the second dose incorrectly increases complications for the woman and she may require surgery. As many as half of all recommended protocols for prescription drug use are not followed, or not followed correctly. (Hovstadius B & Petersson G (2011) Non-adherence to drug therapy and drug acquisition costs in a national population – a patient-based register study. BMC Health Services Research 11:326)
• Emotional distress. Carrying out a DIY abortion at home is a painful and traumatic experience for women, who are often alone. Many studies show that women experience emotional distress after an abortion and other studies show mental health problems for women after abortion. Home abortions may lead to more adverse psychological consequences, in part because a woman may be alone when she aborts and may also see the foetus who is expelled.

The possibility of abuse and pressure from a partner. Possible complications remain unknown. Mistakes in the calculation of the gestational age. The woman having no immediate medical support, if problems arise. The only solution is face to face consultation and clinical assessment.

I consider risks to be unacceptably high. Women are being certified for abortion without seeing a doctor in person. This increases the risk of potentially life-threatening conditions, such as ectopic pregnancy, being missed.
It concerns me that potent medicines are being sent through the post with no sure way of knowing who will take them. There is no way of knowing at which point in the pregnancy the drugs are being taken – as seen with one woman
found to have aborted her baby at 28 weeks.
In my view, a true assessment of the risks of home abortion must include the mental and physical consequences of an abortion for the mother. These include:
- Increased risk of subsequent premature births;
- Higher risk of mental health problems;
- Complications such as haemorrhaging

Powerful drugs are sent through the post without knowing who will take them, there is no way of knowing at which point in the pregnancy the drugs will be taken.It is possible for a young girl to take the pills to school and who knows what the result of that would be for her. Women are given the right for Abortion without seeing a doctor in person ,this increase the risk of potentially life threatening conditions,A true assessment of the risk of home Abortion must include the mental and physical consequences of an Abortion for the mother. Abortion increases the risk of subsequent premature births,High risk of mental health problems,Complications such as haemorrhage ,a mother needs to know all the risks of an Abortion.

The lack of regulation and supervision implicit in these measures would almost certainly lead to misuse, exploitation and coercion. I cannot believe that the obvious risks and dangers are being overlooked and trivialised.

Whatever the “risks” might be for the mother to be ,these can be mitigated by good, sound counselling and basic human kindness. In probably 99.9 cases , there’d be no “risks” if available precautions would be adhered to.

Some have argued that a risk of home-use is that women will attempt to access the medication when they are beyond 10 weeks gestation.

There is a lot of evidence that indicates that people can reliably date their pregnancies using their last menstrual period. Research shows us that of all abortions involving both pills being taken at home only 0.04% occurred in cases whereby the woman was more than 10 weeks pregnant (Aiken et al, ‘Effectiveness, Safety and Acceptability of No-Test Medical Abortion Provided by Telemedicine, 2020: https://www.medrxiv.org/content/10.1101/2020.12.06.20244921v1).

There is also evidence that medication abortion is safe past the 10 week gestational limit that is recommended in the UK (see the 2012 World Health Organization abortion care guidance, page 45). The use of the medications later in pregnancy only slightly increase the risk of complications. It may be more painful for women and the products of the pregnancy that she passes may be larger than she is expecting. However, service providers such as BPAS have 24/7 support lines, so women are supported with any concerns or worries they have with their post-abortion care.

I have recently produced an article for The Conversation (https://theconversation.com/banning-safe-home-use-abortion-pills-will-leave-more-women-in-crisis-154594) in which I argue that we should abortions that take place in later in pregnancy (notably after 24 weeks) as distinct from home abortions). As I argue, whether home-use continues or not, a very small number of women will continue to illegally access medication to end a pregnancy of a viable foetus. Abortion medication is relatively easy to obtain illegally via the internet. In 2015 and 2016, 645 abortion pills were seized en-route to addresses across Britain. It is likely that far more made it to their destination. Home-use will reduce some women’s desperate need for this illegal trade.

Women who are in desperate circumstances are distinct from the vast majority of abortion cases that occur. And those who do find themselves in the position of needing to end a late-term pregnancy are incredibly vulnerable. My research shows that women in this situation experience what is known as a “crisis” pregnancy. An unwanted pregnancy is not necessarily a crisis pregnancy, if a woman has access to safe and legal abortion services.

The crisis arises because of difficult life circumstances these women are enduring, such as living in violent and abusive relationships or living poverty with limited social support.

Considering the stage of the pregnancy, the dire context that surrounds them and the steps women take to end them, these crisis cases need to be seen as distinct from “regular” abortions, which generally occur very early in the pregnancy – with just 0.1% taking place at or after 24 weeks, according to national data from 2019. Most of these post-24 weeks terminations will be of wanted pregnancies following a diagnosis of foetal abnormalities.

My research has shown that crisis pregnancy cases are, in fact, more akin to newborn infanticide. This is when a newborn baby is killed with the child’s mother being the most likely suspect. In these cases the woman often acts out of fear, shame and a belief that their pregnancy cannot exist. There needs to be a debate about whether it is right to criminalise these women, considering their levels of vulnerability. I do not believe it is.

Whether or not home-use for early medical abortion is legally permitted, women in crisis will find means to end their pregnancy – they have in the past and they will again.

Governments do not ban alcohol because some people drink and drive. Why should they ban home-use abortion pills because a very small number of women will knowingly be over 10 weeks pregnant when they request the medication?

These vulnerable women need support. And they should not be used to prevent all women from easily accessing safe and compassionate abortion care at home.

Incorrect due dates, health issues.

Given the current situation yes

The main risk is to the life of the mother.
Telemedicine cannot accurately assess the gestation of the unborn child and it is clear that some women are taking the pills outside of the 10 week period. This brings greater risks. there is also no way to check whether the woman is in an abusive/coercive relationship and is not wanting to abort, but is being forced into it. These risks can only be mitigated by the abortion service being provided in a clinical setting

The risks are the same as the safety concerns outlined in our answer to question1 above and repeated below. These can all be mitigated by reverting to require an in-person consultation prior to administering the pills.

1. Providers cannot confirm the eligibility of a woman for early medical abortion at home. This has been clearly confirmed with a Mystery Client Investigation sponsored by Christian Concern which found that in all cases women were able to obtain the pills by providing false information.
https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Abortion-At-Home-A-Mystery-Client-Investigation-201210.pdf
There is also evidence from a leaked email and from press reports that women have taken these pills well beyond the gestational limit of 10 weeks, with significant safety risks as a result.
https://christianconcern.com/ccpressreleases/nhs-email-leak-reveals-diy-abortions-killing-and-harming-pregnant-women/
https://www.thesun.co.uk/news/11690506/police-probe-death-of-unborn-baby-after-woman-has-illegal-abortion-by-post-at-28-weeks-four-weeks-past-limit/
2. Providers cannot confirm that it would be safe for the woman to have early medical abortion. Providers are unable to carry out a scan with telemedicine. A scan could reveal issues with the pregnancy which mean that the pills would be unsafe to take. A leaked email revealed that the Care Quality Commission were aware of 13 serious incidents relating to home abortions as of 21 May 2020.
https://christianconcern.com/ccpressreleases/nhs-email-leak-reveals-diy-abortions-killing-and-harming-pregnant-women/
These included ruptured ectopics, major resuscitation for major haemorrhage, and delivery of infants up to 30 weeks gestation. Three police investigations were linked to these incidents. In October last year, the Department of Health and Social Care revealed that it had been notified of 52 women who had been prescribed the abortion pills even though their gestational age was beyond the 10-week legal limit.
https://christianconcern.com/news/department-of-health-reveals-52-illegal-abortions-at-home/
3. Providers cannot confirm the identity of the woman requesting abortion pills. This has been demonstrated with the Mystery Client Investigation which Christian Concern sponsored which found that all clients were able to obtain pills using false identities.
https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Abortion-At-Home-A-Mystery-Client-Investigation-201210.pdf
This means that the pills could be obtained for another person and that another woman could be pressured or forced or deceived into taking them with significant safety concerns.
4. Providers are unable to check that the woman is not being coerced. There is not a safe private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure.

- Ectopic (increased risk to women). not mitigated - Babies aborting at home above 12 weeks (which has clearly been happening). Risk not mitigated - coercion - for the purposes of forced abortion - tablet seeking - for the purposes of selling the tablets or trading for some other service - potentially inadvertently encouraging prostitution - as false identities can be sought for serial abortions
If the checks are in place I see no reason why there should be an increase in risk. The opposite I would have thought to the client.
• Although no healthcare is risk-free, abortion is a low risk procedure which in all instances is safer than continuing a pregnancy to term • Abortion providers across Wales and Great Britain have worked hard to establish a safe, effective, and accessible telemedical abortion model at a time when all other healthcare has been under substantial pressure. This has meant thousands of women in Wales have been able to access care that otherwise they may have struggled to obtain. • This consultation is rightly only concerned with where the first part of an Early Medical Abortion is taken. Decisions to scan women only where indicated, and how doctors and nurses undertake clinical consultations are based on best medical practice and clinical guidelines – not on government approval. Guidance that routine scanning is not necessary to provide a safe and effective abortion service has been in place since 2011 in RCOG's Guidance for the Care of Women Requesting Induced Abortion. • Around 60,000 women have received telemedical abortion care across Great Britain since the original approval, with no notable difference to the already low risk profile of abortion care.
There are risks to the woman's physical and mental health and wellbeing if she is left to manage the whole process by herself. There is no way of telling if the woman is being coerced into making this decision, or whether she is free to make the decision herself, without anyone else forcing her into the decision. I don't see that these risks can be mitigated if this temporary measure was made permanent.
By allowing women to be certified for abortion without seeing a doctor in person increases the risk of potentially life-threatening conditions eg. ectopic pregnancies, being overlooked.
I think it is safer, services need clear guidelines
There is always a slight risk with any pregnancy, but the risks associated with this measure are lower than those associated with a natural miscarriage.
There are studies which show that a significant proportion of women have taken the pills beyond the 10 week period they are designed for. The pills are then less effective and can have more serious medical consequences for the women. A UK study has shown that over half of women having post 13 week abortions needed surgery. Not getting the precise intervals between the two pills right. The timing between the first pill the second pill is critically important. Taking the second one incorrectly increases complications for the woman that can require surgery. We know that for medicines in general about half of the Instructions are not followed correctly. Having an abortion without emotional support services can cause distress. Any abortion is a painful and traumatic experience for women, and this will be worse if they are alone. Home abortions, without proper support services, are more likely to lead to more mental health issues, especially as the woman may actually see the expelled foetus.
I am concerned that without a physical consultation there is a much greater risk that a woman could be being coerced into seeking a termination and this could be adding to abuse that she is already experiencing. a private consultation with a clinician could give her an opportunity to explain her circumstances and ask for help
Early abortion is lower risk than continuing pregnancy to term. Telemedical service has allowed access during the difficult time of the pandemic.
There is a clear risk of women being coerced into having an abortion. There would not be the freedom to disclose this threat on the telephone with the coercer without earshot. This could be mitigated by having mandatory face-to-face appointments.
Yes, negative impact. You don't know who is at home with the woman. You cannot know whether she is being coerced. In a clinic the woman is always seen alone for at least some time to ensure that she is not being coerced. Woman may go through traumatic abortion experience with only an abuser present. Providers do ask if woman is alone, in private, safe. They will ask several times. Some of the questions are quite involved and explore, for example, domestic violence, but it doesn't matter how good the questions are, on the telephone the provider simply cannot know whether or not the woman is actually alone, in private and safe.
I have one I have experience of one young lady who collected these tablets from an ambulance in our local town and administered them herself in her bedroom as her mother was so furious with her becoming pregnant she wouldn't have anything to do with her. The young lady had a very traumatic experience and ended up in hospital haemorrhaging and with blood clots in her veins.
As stated in Q1, women are able to obtain pills on the phone by providing false information. They may be subject to coercion. Their identities cannot be properly checked.
I see no risks, as long as medical care should continue to be available
There is no medical supervision or advice of the drugs being taken.
There may be risks to women who may be bullied and coerced by partners who are perpetrating domestic abuse.
Although no healthcare is risk-free, abortion is a low risk procedure which in all instances is safer than continuing a pregnancy to term • Abortion providers across Wales and Great Britain have worked hard to establish a safe, effective, and accessible telemedical abortion model at a time when all other healthcare has been under substantial pressure. This has meant thousands of

women in Wales have been able to access care that otherwise they may have struggled to obtain. • This consultation is rightly only concerned with where the first part of an Early Medical Abortion is taken. Decisions to scan women only where indicated, and how doctors and nurses undertake clinical consultations are based on best medical practice and clinical guidelines – not on government approval. Guidance that routine scanning is not necessary to provide a safe and effective abortion service has been in place since 2011 in RCOG's Guidance for the Care of Women Requesting Induced Abortion. • Around 60,000 women have received telemedical abortion care across Great Britain since the original approval, with no notable difference to the already low risk profile of abortion care.
Women can be pressed by others, into taking the pills, against their will. The time limits and guidlines for taking the pills can be misinterpreted without professional guidance.
Those who feel safer in clinic should be given that option- choice is key here.
There are no increased risks. Studies show that there is no deterioration in safety, rather the reverse. The ability to take both pills at home, and sooner than would be possible by a clinic attendance, is preferred by virtually all women, and the vast majority of them prefer this system. I do not consider that there are any increased risks, since the option of a clinic attendance is available if either the doctor or the patient thinks it is needed.
I genuinely do not believe there are any risks. There may be concerns from some about safeguarding issues, however these can be assessed for remotely (and as previously mentioned above women may be more willing to disclose issues) and face to face appointment can be offered or even advised if concerns/ it was felt to be beneficial. This should be something that is down to training of staff and clinical proformas as opposed to something that needs to be set by the government. Others may have concerns about risk of underdetection of ectopic pregnancies, however there are robust methods for assesing this risk and the reaserch that is coming out has already showed that there is no incrased risk from ecopic and actually they may even be detected earlier. I can only see benefits from continuing to offer telemedicine as an option.
Identify individuals using this medication multiple times to offer and provide support and education about preventing pregnancy. Look at the situation and provide appropriate advice
1. Providers are unable to confirm eligibility of women for early medical abortion at home since they are unable to carry out a scan which identifies the gestational age of pregnancy and possible complications e.g. ectopic pregnancy. 2. Women may not know risks of taking pills after 10 weeks.
This is a 'closed' question. To elicit a valid response, the question should read: ""Do you consider there are any risks associated with the temporary measure?"" It should be followed with: ""Please give details if you consider there are risks."" Such a leading question invalidates responses.
There are many risks which include: - taking the abortion pills at the wrong time - later than 10 weeks into the pregnancy which causes greater danger to the woman's health and is very likely to require surgical intervention. - leaving an incorrect time interval between the first and second dose of the pills can cause complications for the mother's health. It has been noted that this situation occurs quite frequently. - the emotional distress felt by women who have to deliver their aborted foetus is very great. This often has a lasting traumatic effect on them. They are most often alone when this takes place and this experience greatly affects their emotional and psychological well being.
A major risk is that women could take the tablets incorrectly and/or beyond the gestational legal limits of 9 weeks and 6 days (knowingly or not). Also, there are more risks and harm to the woman if the second tablet is taken at a wrong time. If the woman has been abused and then coerced into abortion, this might be a traumatic experience, and can perpetuate the cycle of sexual abuse. The pregnancy might be between 2-3 cm in size, size of grape/olive/bean/cherry and the expulsion and disposal of it can be very traumatic and psychologically distressing (as the woman might see the pregnancy). The women could be alone without any support available.
There are risks involved in all healthcare provision, but the risks in this case should be considered as the very low risk of abortion at less than 10 weeks gestation compared with either accessing abortion illegally or continuing with pregnancy, both of which carry a much higher risk. This document is looking at one particular area of abortion care which is where the first part of the treatment is taken, which in itself plays no discernible part in the risk posed by EMA (Early Medical Abortion) The overall risks of early medical abortion can be mitigated by careful adherence to remote abortion pathways, which are themselves based on best clinical practice and supported by Professional bodies such as the RCOG (Royal College of Obstetricians and Gynaecologists) and the FSRH (Faculty of Sexual and Reproductive Health).
Same answers here as to question 1. Emotional distress to the woman, who can not know when the effects of taking the pills will happen, she may be at work or shopping and the disposal of the remains would be distressful and harrowing to all concerned. Conversely she may be totally alone and find herself traumatised and unable to cope.
There are no significant increased risks within the current guidelines, which do not support general testing e.g. by ultrasound in clinics.
Providers cannot confirm the eligibility of a woman for early medical abortion at home. A Mystery Client Investigation, which found that in all cases, women were able to obtain the pills by providing false information. Providers cannot confirm that it would be safe for the woman to have early medical abortion. Providers are unable to

carry out a scan with telemedicine. A scan could reveal issues with the pregnancy which mean that the pills would be unsafe to take.
Providers cannot confirm the identity of the woman requesting abortion pills.
Complications in the pregnancy could be missed due to lack of scans and proper checks that would otherwise be done in clinic, eg. ectopic pregnancy.
Providers are not able to confirm the gestational age of the pregnancy. Women could be given the pills even if the pregnancy is over 10 weeks' gestation. There is too great an ease of access and too much dependency on the woman to be sure of gestational age.
Providers are unable to check that the woman is not being coerced. There is not a safe, private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure from an abusive partner or parent.
Women should be given full information about the risks of abortion carried out at any gestation and under any circumstances, but especially about the risks of taking the pills after 10 weeks.

Home-delivery of these powerful treatments cannot ensure that they will be used for correctly, or by the person who made the original request.
A mental and physical assessment of the woman requiring the procedure cannot be adequately made.
Risks include: - increased risk of subsequent premature births;
- higher risks of mental health problems;
- complications such as haemorrhage.

Quite simply the risk to the health of those carrying the child both mental and physical. No chance for a women to be told the risk of such an abortion - physical risks around the procedure, risks of later infertility and mental health problems.
Risks that women may be coerced into aborting their child. There is no way of knowing who the pills might really be for and whether they will be used in the right way. Young people, teenagers even may be taking them having talked to now one else and having absolutely no support from anyone. Risks that a child may be aborted at any stage of the pregnancy,. I do not believe that any of these risks can adequatley addressed by an online consultation. No opportunity to pick up other problems such as ectopic pregnancies.
8. Abortion at Home: a Mystery Client Investigation, Christian Concern, July 2020 . This shows how easy it was to access a diy abortion kit using a false NHS number with no checks on the gestational age of the feotus and check on who might be using them.

The temp measure removes the necessity for discussion before accessing an abortion.
The temp measure confuses women into seeing a option as a form of contraception. The morning after pill has now been superceded by the 10 week after pill.

The temporary measure should cease.

Unverified gestational age of the pregnancy
Any medical problems of the woman not identified
Fraudulent claims on identity and age
Women in relationships who could be forced to take these pills against their will
The above could be mitigated only by face to face consultation at a clinic .

I'm not sure how certain people can be that they are less than 10 weeks pregnant. I assume that this might be easier to check in a face to face consultation. There must be a temptation for the person seeking an abortion to minimise the gestation period in order to be able to proceed at home. If they are in fact over 10 weeks pregnant then there are presumably increased risks in taking these pills and triggering an abortion.
Disposal of the aborted foetus must be a harrowing experience, which is surely better done in a clinic where there are well established procedures, rather than at home.
There is also the risk that the mother is being coerced into doing something which deep down they do not really want to do. This risk must inevitably be greater when there is no face to face consultation.

Four potential concerns that might be raised about the modified management of those undergoing EMA are: a) uncertain gestational age due to lack of routine ultrasound scanning, b) late diagnosis of an ectopic pregnancy, c) difficulty in perception of non-verbal cues relevant to an unstable decision about abortion and to safeguarding issues and d) committing to initiation of the abortion process and taking the medicines away from medical supervision.

With regard to a), the 11 cases in the national cohort telemedicine-hybrid group that were at more than the expected 10 weeks all completed the abortion at home without additional complications.

With regard to b), although routine ultrasound scanning is not necessary, clinical guidance for remote care excludes women who have risk factors for or symptoms/signs suggestive of an ectopic pregnancy. Routine scanning in symptom-free women without risk factors is questionable as it may aid detection of some cases but falsely reassure others that a pregnancy is intrauterine. The absolute incidence of ectopic pregnancy in those undergoing abortion is known to be ten times lower than that in the general population. The general population are not seen in person and scanned unless they have symptoms of an ectopic pregnancy. There is no clinical justification for maintaining an inconsistency in care between those continuing their pregnancy and those choosing EMA.

Regarding c), the experience of BSACP members is the converse; their experience is that women can talk more freely and openly when consulting over the phone than in a clinic. Many people are intimidated by medical consultations and, with abortion care being so intensely personal and private, face-to-face discussions can be perceived as threatening. Many women expect to be judged, given the stigma attached to abortion care – an expectation reinforced by the frequent protests that occur outside abortion clinics (https://bsacp.org.uk/wp-

content/uploads/2020/10/BSACP-Position-Statement-Protests-18082020.pdf). In contrast, people are accustomed to talking over the phone and when consultations are conducted from the privacy and safety of their own home, they are more likely to be open and honest, rather than feeling obliged to offer answers they perceive to be expected of them. This impression is borne out by consultations often taking longer over the phone – as the patients simply talk more – and that rates of identification of safeguarding issues have increased.

Finally, with respect to d), it is clear from experience so far that women are well able to make the decision to swallow the mifepristone by themselves in the privacy of their homes. Taking both mifepristone and misoprostol at home has been routine practice across the world for many years and has an excellent safety record.35 36 The deregulation of mifepristone in Canada in 2017 has not resulted in a clinically significant increase in abortion complications, continuing pregnancy or adverse events. Mifepristone is a very safe medicine with fewer spontaneous adverse drug reaction reports than both sildenafil (Viagra) and paracetamol.

The evidence (https://doi.org/10.1111/1471-0528.16668 Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study. Aitken et al. 2021) shows that home-use of misoprostol and mifepristone is as safe as in clinic visits. An extremely small number of women had abortions at higher gestations than 10 weeks (0.04%) but these were all completed safely and effectively. This is a risk women are counselled for during their consultation - and the content of such a consultation should be at the discretion of the healthcare providers NOT the government.

Sending medication to women in the post is potentially very unsafe. Who ensures that the medication isn't used for someone else or accidentally taken by a child etc?

Risks that have been raised have been regarding privacy, safety, safeguarding.
See above answers regarding privacy, safety.
Studies into the telemedical changes for abortion have not shown a reduction in safeguarding cases being picked up.
Another concern has been the chance that women would be having abortion at home at a later gestation of pregnancy than they were expecting.
Women are being appropriately counselled regarding what to expect and what to do to access help and support if they feel they are experiencing something outside of the norm.
It is down to the healthcare service and healthcare providers to consider via national clinical guidance what is the safe and appropriate information to discuss with a women accessing their care. This is not under the remit of government or law - no other healthcare provision is subject to this.
Recent studies have shown a tiny number of women (0.04%) have had at home mifepristone over the arbitrary 10 week gestation limit and all had successful home abortions without complications.
Scotland has run mifepristone and misoprostol telemedicine abortion safely with a 12 week gestation limit.
The majority of women are able to correctly determine their gestation from last menstrual period or when unprotected sexual intercourse occurred.

In my experience as a doctor providing abortion care I would recommend women be told:
● If the date of their Last Menstrual Period is wrong it may mean that the pregnancy is greater in duration than estimated.
● The risk of getting the duration of the pregnancy wrong, based on their last period, is 1 in 1000 or lower.
● If the number of weeks is more than estimated for a medical abortion, it could mean that the abortion pills might not work or that they might work but the pain and bleeding could be more than expected, and the foetus might be more developed than expected.
● If the number of weeks is more than estimated for a surgical abortion, it could mean that you could be sent to a unit with a gestation limit that is too low, and treatment has to be rescheduled elsewhere

Mae erthyliad yn weithred feddygol o risg isel iawn, ac mae'r dystiolaeth yn dangos fod y drefn hon wedi bod yn ddiogel tu hwnt. Mae 60,000 o ferched wedi cael erthyliad o dan y drefn newydd ers y pandemig ac nid oes unrhyw dystiolaeth o newid mewn risg, lle mae risg eisoes yn isel iawn.

There are huge risks, because these powerful drugs are being supplied with no control over who is going to take them. There are no adequate safeguards in place. Providers are not able to check the identity of the people requesting the treatment. There have been instances where they have been supplied, on the basis of false information, to people who were not even pregnant women. There are not enough questions being asked or enough checks being put in place. Domestic abuse has increased during the pandemic and providers have no way of knowing if the woman is in an abusive relationship and is being coerced into having an abortion. If the woman could attend a clinic, she would at least have a safe and private opportunity to discuss her situation. There is no safeguard to ensure that the pills will not be taken beyond the 10 week limit, and there is no safeguard that they are not being supplied to young and vulnerable girls in schools, who are in danger of being exploited or abused. Even in cases where they are supplied to genuine patients, there are still risks. Women are certified without being examined by a doctor, which carries a danger that life-threatening conditions such as ectopic pregnancy may be missed. There is no aftercare or follow-up for women who carry out these home abortions, which means they have no support in dealing with the subsequent mental health problems or in dealing with possible complications such as haemorrhaging.

I think there will always be a concern that vulnerable pregnant folk could be pressured into a termination (for example by an abusive partner, parent etc) but I think these risks are present even with traditional abortion services.

It has been shown that taking the pills after 10 weeks is harmful to the women, the UK study has shown that more than 50%of women having abortion after 13 weeks have needed surgical intervention , the timing between the first

and second dose is critical, if taken incorrectly can cause complication where she may need surgery , having a DIY abortion at home can be painful and traumatic , especially if the mother see and or handles the baby.

There are many risks.

First of all, there are the inherent risks associated with the medications Mifepristone and Misoprostol, the drugs most commonly used in inducing medical abortion. These risks include the potential for major haemorrhage; requiring hospitalisation and blood transfusion in many cases. There is an additional serious risk of sepsis, resulting from incomplete abortion and, in some rare cases, this risk includes the risk of death. Two deaths of mothers associated with undergoing medical abortions were allegedly reported in the UK in 2020. More than 24 deaths of women undergoing medical abortion have been confirmed in the USA in recent years. These risks to the physical health and life of the pregnant woman are higher in later pregnancies.

The absence of face to face consultations, with the abortion provider never actually meeting the person requesting abortion, increases the likelihood that abortions will be carried out at later stages than is allowed by the current law and therefore increases the likelihood that these complications will occur in significant numbers, placing patients at considerable risk. There have already been many reports that the law has been broken by provision of abortion pills without any supervision and abortions being carried out at later stages than currently allowed by law.

There are, however, many more serious risks that are directly related to the temporary measure of allowing abortions to be carried out without face to face encounters with the client potentially seeking abortion. The most serious risks are those related to the potential for abuse of the telemedicine system. Without face to face consultations, there is no way that the person providing the abortion pills can ascertain that the person they are in communication with is actually the woman seeking an abortion. This system makes it very easy for others to obtain abortion pills and administer them surreptitiously to a pregnant woman without her consent. Similarly, with this temporary telemedicine system, there is no way for the provider to be certain that a woman seeking the abortion pills through a telephone conversation is not being coerced into doing so against her will. The system allows abuse of minors and victims of sex trafficking to remain undetected simply because it is so easy to obtain the abortion-inducing medications to administer to others.
The absence of face to face consultations also means that some ectopic pregnancies will go undetected until potentially life-threatening complications occur. In standard practice, most pregnant women receive the benefit of undergoing ultrasound examinations to ensure that their pregnancy is viable and within the uterus. This ultrasound scanning service is absent from a service provided by telephone conversations alone.

There is sadly no way for these risks to be mitigated without face to face consultations and proper medical supervision. Even with face to face consultations, the risks associated with women suffering serious haemorrhage, sepsis and the psychological trauma of seeing the aborted foetus in many cases remain, as Mifepristone and Misoprostol are not benign medications. The potential for some of the other risks outlined above can be reduced and warning signs of potential abuse can be more easily identified with face to face consultations.

Risks involve : A woman being left in a dangerous medical situation on her own ie: in a lot of pain, losing a lot of blood and clots.
Body parts being left in the uterus after the abortion, leading to infection
Women who are being coerced into an abortion, not receiving the help and support they need.
Women being sent the pills who have lied about the pregnancy , to either: take the pills when they are further along than 10 weeks or to procure the pills for someone else, as has been proven possible
https://percuity.blog/mystery-client-survey/
A woman suffering mentally after the abortion, on her own, leading to depression, and impacting other family members.
These can all be mitigated by the woman seeing a health professional throughout the process, who is invested in her needs and the needs of her family.
Any abortion provision is also a huge risk to the baby of course. The one person in this situation who will never have a voice.

From our experience in speaking to countless post-abortive women, we know that there are risks to women with any abortion procedure. However, these risks increase with early medical abortions at home as she is self-administering medical abortion pills with no medical supervisions whatsoever.
Risks to women carrying out an early medical terminations at home include:

• Taking the abortion pill at the wrong gestational age - It is not advised that abortion pills be taken at home past 10 weeks gestation. The physical risks associated with medical abortion increase as the pregnancy progresses. One UK study found that more than 50% of women having abortions after 13 weeks needed subsequent surgical intervention. Without an in-person appointment, there is no way for the doctor to confirm that the woman requesting abortion pills is in fact at 10 weeks gestation or earlier.
• Not adhering to the precise time intervals between the two stages of the abortion - The timing between taking Mifepristone (the first pill) and taking Misoprostol (the second dose) is critically important. Taking the second dose incorrectly increases risk of complications for the woman and she may require surgery. As many as half of all recommended protocols for prescription drug use are not followed, or not followed correctly. Expecting women to self-manage this treatment increases the risk of complications as a result.
• Emotional distress - Many studies show that women experience emotional distress after an abortion and other studies show mental health problems for women after abortion. Home abortions may lead to more adverse psychological consequences, in part because a woman may be alone when she aborts and may also see the foetus

which is expelled. We have spoken to countless women about the emotional distress they faced after an abortion experience.

I think it makes it sound more user friendly (with the inherent risk that it can trivialise the emotional impact on some women.) However there are also risks that these drugs are more open to abuse - either as to who takes them, or where they are taken and if there is any support if something goes wrong; at what point does heavy bleeding become an emergency? How is a frightened woman on her own, possibly in secret or under coercion to obtain timely help? What happens if an undiagnosed ectopic pregnancy has occurred? How much support is available for those who find it a much bigger emotional deal than anticipated and whose mental health suffers as a result?

As in Q1:

No, it has had a negative impact

It is simply not possible for service providers when solely using telemedicine to be certain of a woman's eligibility or suitability for early medical abortion at home. They are relying on the woman's accurate, complete, and honest declaration about her current state of health, her medical history, and the gestational age of her pregnancy, based on her recall of LMP. Women might not always get this right, or they may deliberately mislead the provider. This is important because the potential harm of side-effects or adverse events increases with gestation and are more critical if an ectopic is missed. In the mystery client investigation which I led, we recorded 26 cases out of 26 in which women were able to obtain the abortion pills for use at home, whilst providing incomplete and inaccurate information, especially related to the date of their LMP.

The DHSC, in response to a freedom of information request FOI-1250644, released data reporting 52 cases in England and Wales in which the gestational age was beyond the prescribed 10 week limit for abortion at home. An NHS email on May 21, indicated concerns about the escalating risk around the pills-by-post process, noting that the CQC was at that time aware of 13 incidents arising from this process. The writer of the email notes that this is a small number of incidents but each with tragic, poor outcomes for women. They also note that these are just those incidents which the sector deems 'significant', requiring reporting to the regulator, and that many other adverse outcomes are seen to be 'normal' complications of medical abortion.

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

http://percuity.blog/nhs-email/

BPAS shows on its website the increasing incidence of side-effects and adverse events, when comparing <9 weeks and the tenth week. The rate of incomplete abortion rises from 3% to 7% in just that one week, and medical guidelines show that it continues to increase with increasing GA. The clinic visits which were a routine integral part of the abortion care pathway before the March 30 approval, included a professional clinical assessment of eligibility and the use of ultrasound scan to confirm the gestational age.

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

In our investigation we conducted cases with each of BPAS and MSUK in which the woman's coercive partner was sitting beside her during her calls. When asked by the provider if she is safe and on her own, she answered yes. During these calls, the coercive partner can be seen prompting the woman to give particular answers to critical questions. When solely relying on phone calls, abortion service providers are simply not able to detect if their client is safe and alone, or actively being coerced. These particularly vulnerable, at risk, women need the privacy of a safe counselling space in which a trained professional can take time to provide client-centred care.

http://percuity.blog/mystery-client-survey/

The investigation completed five cases in which the woman making the calls was not pregnant and was phoning to obtain the abortion pills to be administered to another person. The persona we used was a non-pregnant mother calling to get the pills for her pregnant adolescent daughter, who she wanted to keep out of the 'system'. In the real world, outside of the investigation, it is impossible for service providers solely relying on phone calls, to know who the abortion pills will be administered to. Whereas when an in-clinic consultation is mandated, the service provider is able to confirm the client's eligibility for EMA and be certain that it is the woman present that the prescribed pills will be administered to.

Prior to the March 30 approval, it would have been fair to say that early medical abortion can be a safe and effective method of abortion, even when the expulsion occurs at home, in large part because of the routine in-clinic consultation and assessment. When relying solely on remote telemedicine consultations, this is no longer the case, this approval has had a negative impact on women's safety.

It would be fair to note that the inclusion of telemedicine can improve the accessibility and convenience of services, but telemedicine should not be the whole of the process.

There is no doubt that the inclusion of telemedicine into the overall abortion care process can help to reduce time delays and costs, for both the service provider organisation and its clients. Telemedicine is appropriate for the initial contact between a woman and her chosen service provider, and for follow-up post-procedure. However, telemedicine

alone is not sufficient to ensure a safe and accurate assessment of a woman's eligibility for an early medical abortion at home.

The 2019 NICE guideline 'Abortion Care' is often cited as recommending the use of telemedicine for abortion assessments, but this is far from definitive. Indeed, the recommendation to consider providing abortion assessments by phone is in the context of making it easier and quicker for women to access this service. The implied context in this guideline is that phone calls should be considered as part of the process, rather than becoming the whole of the process.

It is worth noting that this same guideline also recommends that abortion can be provided without first needing to use an ultrasound scan to definitively confirm the pregnancy. This has been cited as rationale by RCOG for the no-test protocol in its updated guideline for early medical abortion care management during the COVID-19 pandemic. However, the context for this NICE recommendation is that organisations providing a surgical abortion without prior ultrasound scan will need to have staff trained to inspect the products of conception for the presence of chorionic villi and a gestational sac. When providing medical abortion without prior ultrasound scan, the organisation must be able to assess serum human chorionic gonadotrophin (hCG) and have staff trained in interpreting test results. This implies that the NICE no-ultrasound protocol is in the context of an overall abortion procedure which includes some clinic-based processes.

This NICE guideline predates the March 2020 change in which abortion-at-home was approved. It was written prior to there being government approval for the abortion procedure to be completed on a fully remote basis. When considering a fully-remote procedure, it is unsafe to rely upon recommendations made for an abortion procedure which included some in-clinic processes and some remote by phone. We should not adapt these recommendations from a hybrid-location to a fully-remote basis, without first completing a comprehensive safety review based on primary research.

We acknowledge that some women live at distance from their nearest abortion clinic and do not have easy or affordable access to transport. Our recommendation is that rather than relying solely on telemedicine, it would be safer and more effective to provide financial assistance to those women who need it, to cover their out-of-pocket expenses for travel, time away from paid employment, childcare costs, and any necessary overnight stays. This is already a proven process for women living in Northern Ireland who have to travel to England to access services.

It has been argued by some groups that this risk profile justifies all women requiring a transvaginal scan, to determine the duration of the pregnancy. However, this would result in a significant amount of expensive, clinically unnecessary, invasive procedures which would be a wholly disproportionate response. Legally requiring an ultrasound scan is also beyond the scope of the provisions of the Abortion Act 1967 and would require further legislation.

Undiagnosed ectopic pregnancy

With regard to undiagnosed ectopic pregnancy, the algorithm which determines eligibility for an EMA at home includes an individualised risk assessment of ectopic pregnancy, including a discussion of symptoms. The Aiken study notes that the EMA at home model resulted in very low rates of undiagnosed ectopic pregnancy, the rate of missed ectopic pregnancy on the EMA at home model was equivalent to the traditional pathway (0.2%). The authors also note that treatment with mifepristone and misoprostol in itself will have no effect on an underlying ectopic pregnancy. As such, there is no clinical reason to require women seeking abortion to have an ultrasound prior to treatment.

The Aiken study also notes that the reduction in waiting times afforded by the EMA at home model could actually facilitate earlier detection of ectopic pregnancy than traditional pathways in future. On a traditional medical abortion pathway, women present later or are sent away to give additional time to visualise an intrauterine pregnancy on scan. Proceeding with a medical abortion without a scan may permit earlier diagnosis of a developing ectopic pregnancy owing to increased surveillance and index of suspicion, for example where there is minimal bleeding after misoprostol.
Further, if women do have an ectopic pregnancy and proceed with an early medical abortion, those women will have information from providers about what will happen should the pregnancy be ectopic and advice about the next steps. In addition, women will have a 24/7 aftercare line for support if they have any further questions or need advice.

The authors also point out that as the general population is not required to undergo routine scanning for ectopic pregnancy before continuing with a pregnancy, it would be inconsistent and inequitable to require women seeking abortion to undergo an ultrasound scan prior to treatment. (https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.16668) Again, legally requiring an ultrasound scan is also beyond the scope of the provisions of the Abortion Act 1967 and would require further legislation.

Adverse reactions or complications

As demonstrated by the Aiken study, there was no evidence that significant adverse events were higher amongst those who had an EMA at home. Some groups have claimed that following the correct regimen for administering the abortion pills is difficult, leading to complications and unsafe abortion. We have seen no evidence to support that claim, and all providers of telemedicine abortion include step-by-step instructions to follow (https://www.bpas.org/abortion-care/abortion treatments/the-abortion-pill/ remote-treatment/). The national cohort study, as we have seen, reports complication rates which are equivalent to the traditional model, but with higher

efficacy. In addition, providers operate 24/7 helplines for post abortion care, or any other support women may require with the process.

In addition, a majority of patients (75.8%) surveyed by BPAS felt that the procedure was straightforward, 20% mostly understood but had some questions, and only 1.6% felt they needed more guidance. (https://bit.ly/2KDcPRG) Similarly, 92.4% of patients surveyed by Marie Stopes UK felt they 'definitely' had enough information to take the medicines themselves, and 87.4% had no concerns about safety. ((https://srh.bmj.com/content/early/2021/02/17/bmjsrh-2020-200954))

Conclusions re risk and mitigation of same

Given the outcomes of the Aiken study, and the outcomes of the service evaluations conducted by BPAS and MSUK, it would not appear that additional action is required to mitigate risks, over and above the actions already taken by abortion care providers. The Royal College of Midwives has confidence in the excellent service provided by the major abortion providers and further that the abortion care providers will continue to learn from their evaluations and improve services further.

The RCM believes that abortion should be regulated in the same manner as other medical treatments. This means clinical risk is managed by professional guidelines and regulation, not by legislation. Arbitrary legislation, which is not based on safety, efficacy or best practice unduly restricts healthcare professionals' ability to tailor care to women's individual needs and circumstances. This can often mean that some women would not be able to access safe, legal abortion care.

none. Even those risks which were felt possible, such as safeguarding issues, have been found to be groundless. The robust procedures in place to flag safeguarding concerns have ensured the same rates of detection of safeguarding issues before and after the introduction of telemedicine.

I have not heard about any negative outcomes associated with the temporary measure.

It has been shown that there is no increase in risk and scans are only undertaken when really needed.

Complications in the pregnancy could be missed due to lack of scans and proper checks that would otherwise be done in clinic, eg. ectopic pregnancy.

Providers cannot confirm the eligibility of a woman for early medical abortion at home, some may provide false information.
Providers cannot confirm that it would be safe for the woman to have early medical abortion. Providers are unable to carry out a scan with telemedicine. A scan could reveal issues with the pregnancy which mean that the pills would be unsafe to take.
Providers cannot confirm the identity of the woman requesting abortion pills.
Complications in the pregnancy could be missed due to lack of scans and proper checks that would otherwise be done in clinic, eg. ectopic pregnancy.
Providers are not able to confirm the gestational age of the pregnancy. Women could be given the pills even if the pregnancy is over 10 weeks' gestation. There is too great an ease of access and too much dependency on the woman to be sure of gestational age.
Providers are unable to check that the woman is not being coerced. There is not a safe, private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure from an abusive partner or parent.
Women should be given full information about the risks of abortion carried out at any gestation and under any circumstances, but especially about the risks of taking the pills after 10 weeks.

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

Prior to this change in regulation, women were administering misoprostol in their own homes and, for a longer period, have been passing their pregnancies at home after Early Medical Abortion or medical management of miscarriage. Although complication rates are low for both procedures, they are more likely to occur during this stage of treatment rather than at the point of mifepristone administration. Ultimately, therefore, risks of serious complications such as haemorrhage (2 in 1000) which require hospital treatment were already present, recognised, and treated prior to the change in regulation.

The Women's Health CPG has heard from providers in Wales who have worked hard to establish a safe, effective, and accessible telemedical abortion model at a time when all other healthcare has been under substantial pressure. The work of providers and the change in regulation has meant thousands of women in Wales have been able to access safe care that otherwise they may have struggled to obtain.

LATE FOR LMP PRESENTATIONS
Since the change in clinical practice to rely on Last Menstrual Period (LMP) rather than a scan for determining gestational age, there have been a very small number of cases involving gestations outside the 10-week limit for pills at home. The initial indication was that this risk would be around 1 in 1000 – 0r 0.1%. The risk now appears to be significantly lower, at 0.04%. This means you would need to compel 10,000 women to undergo a transvaginal or abdominal scan – which women often find invasive and unpleasant – in order to prevent four cases of a woman

being treated whose pregnancy was in excess of 10 weeks.

This consultation is rightly only concerned with where the first part of an Early Medical Abortion is taken. Decisions about scanning are not within the purview of this consultation or subject to Government approval, but instead are based on clinical guidelines and best practice. Guidance that routine scanning is not necessary to provide a safe and effective abortion service has been in place since 2011 in RCOG's Guidance for the Care of Women Requesting Induced Abortion.

ECTOPIC PREGNANCIES
The prevalence of ectopic pregnancy in the abortion population is very low – in the Aiken cohort study (https://dx.doi.org/10.2139/ssrn.3742277) 0.2% of clients (1 in 500) both before and after the change were diagnosed with an ectopic pregnancy. This compares to 1 in 90 in the general population.

As part of their consultation with clients, abortion providers ask questions to determine the risk of an ectopic pregnancy – including questions about abdominal pain, bleeding, historic of ectopic pregnancy, and history of caesarean section. For those women where the provider identifies a risk of an ectopic pregnancy, they are brought in for a ultrasound scan before treatment is provided.

Outside abortion care, ultrasound scans are not provided as a screening tool in the general population, despite their higher incidence of ectopic pregnancy. In the case of continuing pregnancies, scans are only provided as indicated – where signs and symptoms suggest a need. In this way, the new abortion care pathway is the same as provision for women continuing their pregnancies.

Diagnosis of an ectopic pregnancy is not always straightforward within abortion care, regardless of whether or not a scan is provided. Abortion is provided at such early gestations that evidence of intrauterine pregnancy may not be seen on an ultrasound scan. NICE guidelines are clear that evidence of an intrauterine pregnancy on an ultrasound scan is not required before treatment. In all methods of care, therefore, there is a risk of a woman presenting with an ectopic pregnancy after care has been provided. Regardless, the risk is very low and follow-up care recommends presentation to Early Pregnancy Assessment Units for treatment.

The Aiken cohort study found that 0.01% of clients in the previous pathway were treated for an ectopic pregnancy after treatment (which included a scan), compared to 0.03% in the new pathway.

There are no risks. The evidence is quite clear. Indeed, there are greater risks associated with accessing abortion care the ""traditional"" way - telemedicine reduces the risks.

Concerns are often raised about the potential impact of telemedicine on the ability of abortion providers effectively to safeguard vulnerable patients, but these have proved to be unfounded. Abortion providers have robust services in place to flag safeguarding concerns and address them, and privacy at home may enable pregnant women to talk more freely.

Medical procedures and risk
Abortion is a low-risk procedure which in all instances is safer than continuing a pregnancy to term. Clinical risk is an aspect of all forms of medical care – which is managed by the patient's clinical team in discussion with the patient. In line with the position of leading medical bodies such as the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives, abortion is best managed as medical care between a woman and her clinical team. Abortion providers across Great Britain have worked hard to establish a safe, effective, and accessible telemedical abortion model at a time when all other healthcare has been under substantial pressure. This has resulted in thousands of women in Wales accessing care that otherwise they may have struggled to obtain.
A recent BPAS client satisfaction survey of 1333 clients found that 85% of clients did not contact a healthcare professional during or after their procedure. Of those who did, 78% reported contacting the BPAS 24-hour aftercare line. The principle reasons for contact were to ask questions about administration, to ask about normal levels of pain and/or bleeding, or to discuss aspects of care such as the follow-up pregnancy test. 3.1% of clients contacted a hospital following their procedure – in line with early medical abortion care without a telemedical component.
It should be considered a positive aspect of this change at a clinical level that it is supported by a large number of medical Royal Colleges and clinical groups, including:
• Royal College of Obstetricians and Gynaecologists
• Royal College of Midwives
• Royal College of Nursing
• Royal College of General Practitioners
• Royal Pharmaceutical Society
• College of Radiographers
• Faculty of Sexual and Reproductive Healthcare
• British Society of Abortion Care Providers
• British Medical Association

Ectopic pregnancies
The overall rate of ectopic pregnancy and complications related to ectopic pregnancy are low in the UK. According to NICE, the rate of ectopic pregnancy is 11 per 1,000 pregnancies, with a maternal mortality of 0.2 per 1,000 estimated ectopic pregnancies. In line with other research, the large scale cohort study (https://doi.org/10.1111/1471-0528.16668) found that the incidence of ectopic pregnancy was significantly lower in the abortion population – with 2 in 1,000 clients presenting with an extrauterine pregnancy.
Women seeking abortions are screened for ectopic pregnancy and have historically been exposed to ultrasound scanning at an earlier stage than those who intend on continuing their pregnancies, even though the risk of ectopic

pregnancy is higher in the latter group. In maternity care, ultrasound is not used for routine screening of asymptomatic women, and the first routine ultrasound scan does not take place until 12 weeks. An important part of telemedical consultation and scan screening for abortion services is assessing a woman for likelihood of ectopic pregnancy – including the taking of obstetric history, questions about abdominal pain or bleeding during this pregnancy, and risk factors for ectopic pregnancy. Any woman who is symptomatic of an ectopic pregnancy or who has a risk factor for an ectopic pregnancy will be assessed with an ultrasound scan and referred to an Early Pregnancy Assessment Unit if required. NICE guidelines are clear that Early Medical Abortion can be provided before there is definitive evidence of an intrauterine pregnancy, and the nature of scanning at very early gestations means that detection of extrauterine pregnancies may be both difficult and result in high rates of false positives. There is no clinical risk to patients with an ectopic pregnancy of taking abortion medication – the ultimate outcome is that there is no bleeding and that patients are then referred into Early Pregnancy Assessment Units. The large cohort study (https://doi.org/10.1111/1471-0528.16668) found that the telemedical model 'resulted in very low rates of undiagnosed ectopic pregnancy' (0.03%), with a 'not significantly different' number of ectopic pregnancies detected after treatment in the new pathway compared to the previous pathway. Ectopic pregnancies diagnosed after abortion treatment present a minimal risk which is present regardless of the care pathway. Overall, the incidence of ectopic pregnancy is very low in abortion patients and is not influenced by the care pathway, assessment for ectopic takes place at an earlier gestation in abortion care than for women continuing pregnancies, the majority of ectopic pregnancies are detected prior to treatment in both the in-person and telemedical care pathways, and ectopic pregnancies are not complicated by Early Medical Abortion treatment. Late for LMP presentations Since the change in clinical practice to rely on Last Menstrual Period (LMP) rather than a scan for determining gestational age, there have been a very small number of cases involving gestations outside the 10-week limit for pills at home. The initial indication was that this risk would be around 1 in 1000 – 0r 0.1%. The risk now appears to be significantly lower, at 0.04%, as previously noted. This means you would need to compel 10,000 women to undergo a transvaginal or abdominal scan – which women often find invasive and unpleasant – in order to prevent four cases of a woman being treated whose pregnancy was in excess of 10 weeks. Decisions about scanning are not within the purview of this consultation or subject to Government approval, but based on clinical guidelines and best practice. There could be no clinical justification for supporting an invasive intervention on this basis and for this reason, routine scanning will not be resumed. This means that whatever decision is reached about the future of home use of the first part of Early Medical Abortion, the extremely low risk of a woman receiving treatment outside of the 10-week gestational window will remain.
The Society of Radiographers have seen published evidence to suggest that as long as processes are followed carefully there is limited or no additional risk to outcomes of this measure. If this is a permanent measure, on-going audit and checks should be in place to ensure that any provider follows the RCOG guidance. There should be a very low threshold for requesting a scan to confirm pregnancy location and gestation. Consideration is also needed to ensure that anyone undertaking ultrasound examinations, on those who do require them, are safe and competent to do so, are regularly audited and have enough of a caseload to ensure that they are not de-skilled.
Complications in the pregnancy could be missed due to lack of scans and proper checks that would otherwise be done in clinic, eg. ectopic pregnancy. Women should be given full information about the risks of abortion carried out at any gestation and under any circumstances, but especially about the risks of taking the pills after 10 weeks.
No increase in complications has been seen in our Health Board.
I am not aware of any serious risks. Staff are professional and confidence is high. Follow up support intrinsic to idea
The concerns regarding pregnancies being misdated, and of safeguarding not being performed to the same standard, are addressed in my responses to the other questions. I raise this here to say that these issues are not empirically occurring as opponents to home use of abortion medications suggest, and that there are also measures that can be introduced to mitigate these risks.
women need to speak to a fully qualified accredited experienced Psychotherapist/mental health professional to explored their choices and impact on their wellbeing
There are a number of risks associated with this policy - the providers will not be able to confirm that it is safe for the woman to take this medication, the gestational age of the baby and therefore the degree of risk to the health of the mother which increases the closer this is to 10 weeks or whether the woman is being coerced into this course of action.
I am concerned that these drugs are being sent through the post and no control being taken regarding their use. Normally, for example, when drugs are being given out at the local pharmacy, great care is taken to ensure who is collecting them.
The risks are very substantial: Powerful drugs being sent through the post with no way of knowing who will take them, or, when they will be taken (as in the case of the woman found to have aborted her baby at 28 weeks.) Where are these pills being taken? What if it's in school?...leaving young girls open to the possibility of coercion and abuse. What if they fall into the wrong hands and those for whom they were not intended? Women are being certified for abortion without seeing a doctor in person, risking potentially life-threatening conditions such as ectopic pregnancy being missed. Some women may see the availability of 'abortion by post' as an easy or convenient option, and not give due regard to the prevention of an unwanted pregnancy; this not realizing the future mental and physical consequences of

having an abortion, including the risk of subsequent premature births, mental health problems and complications such as haemorrhaging.
The woman can be co-erred into this by parents , partner and exploiters of women [sex workers/ slaves] , especially for those who are underage teenagers. Without a 1;1 appointment how can you be sure the woman is making a free choice and getting the best advice and support See also GMC report. On domestic abuse which says the obvious that women experiencing DV will hardly be likely to say in front an abusive partner / person that they are being abused , physically , sexually , emotionally or financially. It seem from reports. In the tabloid press that there is no real safety check carried out to stop male exploitation of drug prescription.
There is physical danger to the woman if the abortion drugs are taken later than the 9 weeks and 6 days gestation. They are less effective at a later stage and can cause harm to the pregnant woman. A UK study showed that more than 50 percent of women having abortions after 13 weeks needed to follow on with having surgical intervention. (Oral mifepristone 600mg and vaginal gemeprost for mid-trimester induction of abortion. An open multicentre study. UK Multicentre study group. Contraception 1997; 56:361-6.) Women carrying out a DIY abortion can be effected emotionally and suffer psychological distress.
There are all sorts of risks. Providers are unable to confirm that a woman requesting a home abortion meets the criteria for provision of the kit. They are unable to confirm that a woman is safe to perform an early medical abortion on herself. They cannot even confirm that the woman is who she says she is. Coercion cannot be ruled out and the number of weeks gestation of the foetus cannot be confirmed by e.g. a scan. All in all, this is wide open to abuse and dangerous for women who may well be completely alone during this procedure. I cannot see how, other than by a visit to a clinic, the risks can be acceptably mitigated.
Coersion of the woman by partners most likely on many cases. No protection for the un-born child.
Powerful drugs are being sent through the post with no way of knowing who will take them or at what point in pregnancy they will be taken. How do you know they will be used at home and not say in a school. This obviously exposes young girls at risk of coercion or abuse. A true assessment of a woman for abortion cannot be made without seeing a doctor. Quite clearly these risks cannot be mitigated.
Providers cannot confirm the eligibility of a woman for early medical abortion at home. This has been clearly confirmed through our Mystery Client Investigation, which found that in all cases, women were able to obtain the pills by providing false information. Providers cannot confirm that it would be safe for the woman to have early medical abortion. Providers are unable to carry out a scan with telemedicine. A scan could reveal issues with the pregnancy which mean that the pills would be unsafe to take. Providers cannot confirm the identity of the woman requesting abortion pills. Complications in the pregnancy could be missed due to lack of scans and proper checks that would otherwise be done in clinic, eg. ectopic pregnancy. Providers are not able to confirm the gestational age of the pregnancy. Women could be given the pills even if the pregnancy is over 10 weeks' gestation. There is too great an ease of access and too much dependency on the woman to be sure of gestational age. Providers are unable to check that the woman is not being coerced. There is not a safe, private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure from an abusive partner or parent. Women should be given full information about the risks of abortion carried out at any gestation and under any circumstances, but especially about the risks of taking the pills after 10 weeks.
Abortion providers cannot be sure that an abortion is right for a woman who is being assessed remotely. They can never be sure of the identity of the woman, the stage that the pregnancy has reached, whether there are underlying health issues making an abortion unsafe, and whether the woman is under any form of coercion.
Sending the abortion drugs through the post is clearly unsafe, as the is no control over how they are used or who might get them. There is no face to face doctor consultation to check the potential risks to the woman, which could be seen as medically irresponsible.
Providers cannot confirm the eligibility of a woman for EMA at home. A recent mystery client survey found that women in all circumstances - whether coerced, lying about GA, etc. - were still able to receive the pills by post, even by providing false information. Providers cannot confirm that it would be safe for a woman to have an EMA - they are unable to carry out a scan with telemedicine. A scan would be able to reveal issues with the pregnancy, including ectopic pregnancies, which mean that the pills would be unsafe to take. Women should be given full information about the risks of abortion carried out at any gestation and under any circumstances, but especially about the risks of taking the pills after 10 weeks.
The risks to women's health and their mental and emotional well being have already been referred to. Handling these through remote contact will in many cases be quite inadequate, for the reasons already mentioned. So the temporary measure brings greater risks to women and these can only be mitigated by personal face to face contact.
See answer to question 1. I do not think these risks can be mitigated.
If the Welsh Government is serious about considering the risks associated with early medical abortions, it must include the mental and physical consequences for the mother.

A 2013 study found “a significant increase in the risk of preterm delivery in women with a history of previous induced abortion”. Women who had one prior abortion were 45 per cent more likely to have premature births by 32 weeks, 71 per cent more likely by 28 weeks, and more than twice as likely to have premature births by 26 weeks.[1]

Pro-abortion professor David Fergusson says abortion does not lower the risk of mental health problems for women, and concludes that there is currently “no evidence” that supports authorising abortions on mental health grounds.[2] The Royal College of Obstetricians and Gynaecologists reported that women are more likely to require medical help for bleeding and haemorrhaging after a medical abortion than after a surgical abortion.[3]

The very nature of the current arrangement places women at risk. The removal of direct medical supervision can lead to life-threatening complications. Powerful drugs are being sent through the post with no way of knowing who will take them. In no other context would this be acceptable. It is impossible to ensure that abortion pills will be taken at home and not, for example, in schools. This leaves young girls open to the possibility of coercion and abuse.

[1] Hardy, G, Benjamin, A and Abenhaim, H A, ‘Effect of Induced Abortions on Early Preterm Births and Adverse Perinatal Outcomes’, Journal of Obstetrics and Gynaecology Canada, February 2013, 35(2), pages 138-143
[2] Fergusson, D M, Horwood, L J and Boden J M, ‘Does abortion reduce the mental health risks of unwanted or unintended pregnancy? A re-appraisal of the evidence’, Australian and New Zealand Journal of Psychiatry, 47(9), 2013, pages 819-827
[3] The Care of Women Requesting Induced Abortion: Evidence-based Clinical Guideline Number 7, Royal College of Obstetricians and Gynaecologists, November 2011, page 40

The risks both social and medical of remotely-prescribed abortion are too great for this practice to continue, whatever attempts are made to mitigate these risks. Medical risks include the risk of severe bleeding, sepsis and ruptured ectopics, all of which can cause death. Endler M et al. (2019) Safety and acceptability of medical abortion through telemedicine after 9 weeks of gestation: a population-based cohort study. BJOG 126:609–618 found that surgical intervention was needed for 12.5% of women with GA <9 weeks, and 22.6% for women with GA >9 weeks. Nor is there any way of preventing a woman from taking the pills at a later stage than 10 weeks, whether due to a mistake in dates, or because she feels under such pressure that she deliberately misrepresents her stage of pregnancy, or because she is ambivalent about the abortion and keeps the pills in case she wishes to take them later. Social and mental health risks include the risk of regret and worsening mental health, particularly for those who already have mental health issues. While these risks could be somewhat mitigated by mandating that abortion providers give information on counselling independent of the provider and on practical support from State and voluntary organisations to have the baby, the success of any such requirement would be dependent on more-than-perfunctory compliance by busy abortion providers. It is highly unlikely the woman would be adequately supported in practice to find alternatives to abortion, even if such information provision was mandated. Nor would it be sufficient – although it would be welcome – to have a mandatory cool-off period of several days before the payment was taken and the pills were sent. It is difficult to see any way of mitigating to any great extent the risk of coercion, for example, by a partner or family member who is present at the time of the video consultation or indeed the risk of impersonation by another woman purporting to be a woman wanting an abortion.

Providers cannot confirm that it is really safe for the woman to have early medical abortion. They cannot carry out a scan over the telephone. A scan could reveal issues showing that the pills would be unsafe to take.

Providers cannot confirm the identity of the woman who is requesting the abortion pills.

Providers are unable to check that the woman is not being coerced, e.g. by a parent or an abusive partner.

As above.
Isolated situations for lay people are never ideal.
The Covid lockdown has exacerbated the isolation for so many.
GPs have been described as abandoning their ship.
As a professional, I believe the whole concept at the best of times is physically, psychologically, emotionally and spiritually unsafe.

a. The new arrangements lead to a trivialising of the value and worth of pregnancy and subsequently of abortion. At least by keeping abortion in a clinical setting it can be viewed as more than just a couple of pills. Women will find themselves able to dismiss (or internal pressure to dismiss) the emotional and physical impact of a pregnancy and the value of their ability to reproduce. This might mean that some women may not seek medical help following an abortion because they were under the impression that abortion is “not serious”.

b. Without seeing the woman in person, it cannot be guaranteed what gestation her pregnancy is. She could be taking the pills for a pregnancy that is more than 10 weeks gestation. This could be due to:
• Irregular cycles
• Lack of knowledge about how to monitor her cycle
• Lack of compliance in contraceptive use
• Intentionally misleading the abortion provider e.g. not disclosing the correct gestational age of the pregnancy . In England BPAS was reported earlier this year to be investigating 9 cases where women have taken the pills after the 10 week limit with one of those identified as being 28 weeks. If this happens it could have grave health implications for women. We should not forget that at 28 weeks that baby would have had over a 90% chance of survival.(Find Reference link to Tommys)
c. Research shows that there can be serious complications arising from taking abortion pills and risks escalate with the gestational age of the baby. The potential inaccuracy of the gestational age and the greater emphasis on a private experience raises the possibility that women, especially vulnerable women, will be at a greater risk of

experiencing these complications.
d. There is a risk of haemorrhage in medically induced abortion. The NHS, in describing the risk of bleeding in medical abortions, says “serious complications such as heavy bleeding, damage to the womb, or sepsis: this happens to about 1 out of 1,000 women” (https://www.nhs.uk/conditions/abortion/risks/). We would point out that if women are bleeding excessively and do not receive urgent medical intervention, this can put their lives at risk.
e. The NHS says 7 out of every 100 medical abortions up to 14 weeks require further procedures to remove “parts of the pregnancy” that remained in the womb. The abortion provider BPAS says between 3-7 out of every 100 women between 9-10 weeks experience continuing pregnancy, retained pregnancy tissue or need surgery to complete abortion. For the first three months of the lockdown this year 3% of the medical abortions which took place at home would account for 690 women who were at risk of needing follow up surgical procedures after a medical abortion.
f. There may be situations where teenagers are having the abortions secretly and having to deal with the trauma of seeing the result of the abortion. As a charity which supports thousands of women every year, we hear client stories about the mental harm caused by medical abortion.
• Last year we had a teenage client who said she felt rushed into the decision and had the medical abortion at home on her own. She later experienced feelings of tremendous guilt and sadness.
• Another client said how she regretted taking the pills and now feels ashamed. She was struggling and felt unsupported.
• A third client felt emotionally pressured by her partner into having the medical abortion. She had not wanted the abortion but felt like she had no option. She was still trying to cope after two months and found herself breaking down and crying.

We know of the emotional impact abortion has on women because of the fact that we deal with them every year. During the first five months of the first lockdown last year when home abortions (with both pills taken at home) were approved, Life saw a 44% increase in clients accessing our post abortion support services. During a time when people’s mental health was more fragile, faster and easier access to home abortions put vulnerable women at greater risk by reducing their access to medical professionals. It appears that faster and easier access to abortion was to the detriment of women’s mental health.

With this legislation, medical abortions are being offered by way of posting drugs in the mail so that the pills are then taken with the aim of ending the life of an unborn child. There is no way to confirm whether the person gaining access to such drugs once posted is the intended woman, or indeed whether the person’s identity is genuine. There is also no way of way of knowing whether the woman taking the pills is being forced to do so by their abuser. These risks alone reveal a concerning lack of safeguarding regarding medical abortions, and also demonstrate a lack of concern for providing adequate supervision and consultation.

In regards to ensuring that the service is safe for the woman and unborn child, the research on medical abortions is far too limited, with no substantial evidence that proper safeguarding can be assured. This lack of proper research is revealed by CMF, who state that “For abortions after 13 weeks gestation, the proportion of incomplete medical abortions needing subsequent surgical intervention varies widely between studies, from 2.5% in one study up to 53% in a UK multicentre study”. This incredible variation in percentages does not make for reassuring reading when considering the subject matter is the safety of a woman and unborn child, therefore continuing on the grounds of such a risk is extremely concerning.

What is also of concern with the legislation in regards to the lack of proper research, is that as CMF reveal, “there is little empirical research on the psychological fall out from abortions completed at home”. The worry with advancing with a legislation that places such a high priority on convenience, is that it then risks compromising the wellbeing of the woman, for the sake of proper support and supervision.

Complications are much harder to monitor at home.

It would seem at the very least ""risky"" to send powerful drugs by post with no guarantee as to who receives them, who takes them or indeed where they take them. Especially when the recipient may be a minor.
There is the very real danger of Pills being falsely obtained for another person.
A true risk assessment must include the mental, emotional and physical consequences of an abortion on the mother
Certifying a woman for abortion without seeing a Doctor or Nurse in person increases the risks and denies the woman of the right to have the counselling she deserves before making a life changing decision.

Such risks as:
Had a woman voluntarily requested the pills or had she been coerced?
It is a known fact that domestic violence and sexual abuse has risen throughout this protracted period of lockdowns. How can it be known that a woman is not being forced to take these tablets against her will, to disguise sexual violence such as rape or incest? It could be the perpetrator who acquires them and forces them upon the woman.
There is no way of knowing at what stage the pregnancy is at. It may be past the legal period, thus breaking the Law, and putting the woman's life in very real danger.
And how does one dispose of an aborted baby? If you amputate a limb, is it flushed away? Put in the log burner? Buried under a tree in the garden? Is this not clinical waste? It is a human remain: are you suggesting yellow bags for collection, just like bags for used pads? Frankly, are you equating human life with human waste? And please, spare a thought for the people that make pad collections!

I do not think there are significant risks associated with the temporary measure.

I detail the risks in my answer to Q1 above. The risks are of late abortions due to inaccurate dating (whether unintentional or intentional), including those over 24 weeks' gestation that would not meet section 1(1)(a) of the Abortion Act 1967. There are risks of adverse events associated with incorrect dating, or of ectopic pregancies. There are also risks of coerced abortion. It is impossible to say who might be at the other end of a telephone or video call as well as the patient. The ways to mitigate these risks are to scan every patient to date the pregnancy accurately and to confirm an intrauterine pregnancy, and to ensure every patient has a private face to face conversation with a clinician.

Yes, it has had a negative impact

The nature of telemedicine and speaking on the phone means that women may not be able to speak confidentially on the call without an abuser or coercive family member hearing.
Women may go through traumatic abortion experience with only an abuser present at home.
Although the abortion provider will usually ask the woman if she is alone and in a private place, there is no way to confirm this.

- Providers are unable to check that the woman is not being coerced. There is not a safe, private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure from an abusive partner or parent.
- Providers are not able to confirm the gestational age of the pregnancy. Women could be given the pills even if the pregnancy is over 10 weeks' gestation. There is too great an ease of access and too much dependency on the woman to be sure of gestational age.
- Providers cannot confirm the eligibility of a woman for early medical abortion at home. This has been clearly confirmed through our Mystery Client Investigation, which found that in all cases, women were able to obtain the pills by providing false information.
- Providers cannot confirm that it would be safe for the woman to have early medical abortion. Providers are unable to carry out a scan with telemedicine. A scan could reveal issues with the pregnancy which mean that the pills would be unsafe to take.
- Providers cannot confirm the identity of the woman requesting abortion pills.
- Complications in the pregnancy could be missed due to lack of scans and proper checks that would otherwise be done in clinic, eg. ectopic pregnancy.
- Women should be given full information about the risks of abortion carried out at any gestation and under any circumstances, but especially about the risks of taking the pills after 10 weeks.

In our work offering post-abortion counselling we have found the the majority of women are forced or pressurised into abortions by others (mostly partners or family members) and, we have found, they are not always aware of the pressure or coercion at the time. Clinics and GPs did not always screen adequately for this coercion but without face to face consultations the likelihood of detecting coercion, and being able to support women appropriately, can only be decreased.

How much training do staff undergo on distance consultations (whether by phone or video), and how well equipped are they to verify that the patient is safe and has privacy when talking to her ?
What safeguards are there to verify that the woman speaking to them is even pregnant let alone how far on she is?
What measures are in place to detect exploitation of women? Do providers laisse with anti-trafficking agencies or social work departments over concerns? Has detection of exploitation or abuse increased or decreased during this period?

The majority of women I speak to (who had abortions before the pandemic) felt rushed through the process, including by themselves, and say with hindsight that they should have given themselves more time or been less pressurised to make a decision and complete the procedure quickly. It has been reported that the temporary measure has shortened the time frame, and while that is reported as an advantage, the downside is women might feel even more rushed. Is there any research on the relationship between time frames and e.g. regret, distress or undisclosed coercion?

These risks can only be mitigated by the issues being taken more seriously in the first place - it would be hard to imagine that remote consultations can in any reduce these significant problems.

Abortion is a common and safe procedure; any clinical risks associated with the use of early medical abortion are best addressed by clinical guidelines and not by legislation. NICE made recommendations in 2019 (including the recommendation to utilise telemedicine technology to improve access), and the RCOG have published guidelines specific to abortion care during the pandemic (1).

One risk of the current arrangements is that they are temporary. Evidence shows that telemedicine services are safe and effective, that they improve access (most likely for those in vulnerable situations), and that they are acceptable to the vast majority of service user; so to ignore this evidence in a purely political pursuit of restricting access to abortion for the sake of it would represent a real risk to the health and wellbeing of women and pregnant people across Scotland. To mitigate this risk, regulations should allow telemedicine to become a permanent feature of abortion care provision.

(1) RCOG (July 2020). Coronavirus (COVID-19) infection and abortion care.

1) A major risk of not making at least one visit to a service to be assessed by a clinician outside of the pandemic is if abortion is reduced to just a telephone call and having abortifacient pills delivered then it is likely women in future will not bother with the telephone call and obtain abortion pills illicitly which is an already recognised concern clearly stated on the NHS Abortion risk webpages (https://www.nhs.uk/conditions/abortion/what-happens/) resulting in the total loss of control of this procedure (and degrading of official statistics) which must not be permitted as it could lead

to unsafe abortions risking women's lives. Even with a telephone call and in the absence of a clinic appointment, an ability to prevent the multiple problems for women associated with abortion of domestic abuse, human trafficking, and physical and mental health problems (see below) is lost and which contradicts the UK Government's own advice in its 'Ending Violence against Women and Girls Strategy 2016-2020' document, with cross-party input, that outlines strengthening the role of health services in preventing domestic abuse saying "abused women use health care services more than non-abused women and they identify health care workers as the professionals they would be most likely to speak to about their experience. GPs, midwives, health visitors, mental health, drug and alcohol services, sexual health and Accident and Emergency staff are all well placed to identify abuse. They have the opportunity to intervene early and direct victims to the most appropriate statutory and non-statutory services." (HM Government, 2016, Ending Violence against Women and Girls Strategy 2016-2020, Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/522166/VAWG_Strategy_FINAL_PUBLICATION_MASTER_vRB.PDF, p.21.) Hidden maladministration of illicit abortifacient pills could also be a problem. NHS Wales Informatics Service provided data on the number of hospital admissions in Wales for 2019/20 to be 1,008,400 Finished Consultant Episodes (FCEs) (http://www.infoandstats.wales.nhs.uk/page.cfm?pid=41010&orgid=869) which clearly and incontrovertibly indicates the vast majority of the 9,467 women who underwent abortion in Wales in 2019 were, and for future measures unquestionably are, able to attend a clinic or hospital for their own health and safety (or be seen in person by medical doctor) which overrides any grounds of convenience, preference, or for any other reasons. If women cannot attend a clinic or be seen in person by a medical doctor in some way then this is a matter for authorities such as the police or social services as they could be in peril such as from being trafficked.

2) In the absence of a clinic visit, men can insist on not taking steps to avoid pregnancy if abortion is just a telephone call (or illicit purchase) thereby infringing women's rights not to get pregnant which is a concern recognised in an article in the Daily Mail by Antonia Hughes on the 18th November 2020 again handing men power and control in relationships that could lead to further abuse and coercion.

3) Since the temporary measure reduces levels of care for women to a telephone call it could mean more and worse mental health problems as they believe the Welsh Government and healthcare professionals lack care for them. The Academy of Medical Royal Colleges (AOMRC) in its 2011 'Induced Abortion and Mental Health' multi-study analysis recommends "it is important to consider the need for support and care for all women who have an unwanted pregnancy because the risk of mental health problems increases whatever the pregnancy outcome." (https://www.aomrc.org.uk/wp-content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf) p.8.

4) 1-2% of pregnancies are ectopic and this is the leading cause of maternal death in early-stage pregnant women (https://en.wikipedia.org/wiki/Ectopic_pregnancy) which could be missed if current measures continue with only a telephone call resulting in unnecessary death. Without an ultrasound scan at a clinic then ectopic pregnancy will not always be known which is dangerous.

5) If the Welsh Government's meaning of the lawful killing of unborn babies is reduced to practically nothing because all that is required is a telephone call and respect for human life is absent (nowhere in the Consultation does the Welsh Government acknowledge this humanity - https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx) then this can only lead to a more unpleasant and less civil society where men will view the Government's lack of care for women and respect for human life as a green light for their ill-treatment of women thus further risking their safety.

6) If temporary measures continue outside of the pandemic then the abortion lobby will push for complete decriminalisation which carries the same unacceptable risks for women as above removing even the necessity of a telephone call for this procedure which will lead to unsafe abortions and is completely unacceptable.

These potential risks are
inaccurate gestation due to selective use of dating scans - and some women may therefore be at later gestations
dealyed diagnosis of ectopic pregnancy
failure to recognise safeguarding issues because of remote consultaiotns
initiation of the abortion process away from medical supervision

In Aiken et al's national cohort study of telemedicine for abortion it as found that just 0.04% (11 cases out of 29,984) in the telemedicine cohort had a gestational age greater than the expected 10 weeks, and whilst this will have been an upsetting experience for some of those women they all competed their abortion successfully
Ther was no difference in missed diagnosis of ectopic.
Safegaurding see Q5
Initiation of the abortion process away from medical supervision - see answer to Q1 - this has been happneing from many years already without problems. Mifepristone is a safe and simple medication.

The mitigation of risk is best dealt with by allowing clinicians the freedom to develop good care pathways and not by the use of regulation and legislation.

1) No checks can be made of possible complications which could endanger the health or life of the woman seeking home abortion. An ectopic pregnancy could easily be missed.
2) It has been shown that someone can give false information and a false identity and still be sent the pills. A woman under coercive control or other forms of abuse could be given the pills thinking they are for morning sickness etc. This would not necessarily come to light under these circumstances

Q4: In your experience, have other NHS Wales services been affected by the temporary approval? If so, which?

dk
Probably on emergency services if things have gone wrong in taking these pills.
Yes - I had to wait over 7 months for a simple ultrasound and longer than that for a consultation with a surgeon. Dentists haven't been able to carry out many procedures in their own surgeries.
The NHS is ALWAYS affected by being a party to the deliberate killing of citizens. In my experience over 50 plus years, living in a country with an organisation dedicated at the same time to saving lives and to seeking them out for premature destruction gives a constant feeling of unease, of profound discomfort. Such a wonderful idea as the NHS is tarnished by being involved not in the nurture and healing of the rising generation, but in ever more barbaric and ill-considered programmes of systematic poisoning like the present one. Agencies other than the NHS are also failing to do their duty by not providing, publicising, and enabling alternatives to abortion. Out of those helped by a voluntary agency and enabled to keep, and not kill, their babies, NOT ONE later expressed a regret that they had brought a brand new human being into the world.
Nothing to respond to.
Not that I am aware of.
Don't know
no
Yes, bad health practices.
I have no experience, but I imagine mental health services are likely to have been in higher demand following women aborting babies themselves, in their own homes.
I have no experience.
Probably the Emergency services when it's gone wrong
No experience to draw upon personally on the health service
Don't know
Not applicable.
I recently had a miscarriage and had to present at an Accident & Emergency department due to severe pain and blood loss. I can testify that my medical situation was made significantly easier for the staff, because I had already had a scan which had verified the gestation and location of my pregnancy. A woman presenting to A&E with profuse vaginal bleeding, having taking the abortion pills, without having had any prior scans or any medical appointments, could make it very difficult for staff to make decisions about her medical care. In situations like this, time is of the essence, and having as much prior medical information as possible can be extremely helpful. Allowing women to take medication to cause their abortions without having had proper medical checks and scans, means that potentially NHS staff in Accident & Emergency or in Ante-Natal & Gynaecological departments could be put under more pressure than they already are. Medical abortions have a high rate of complications (20%) compared to surgical abortions (5%), including excess bleeding and infection. Increasing access to medical abortions whilst reducing prior medical checks on these women is a recipe for more strain to be put on the NHS.
I would not know.
I have no knowledge of other NHS Wales services being affected by the temporary approval?
It could be as serious complications could happen as it is not done under direct medical duidance.
No idea.
easy access to abortion will cause more harm than you think, human life is priceless and we are not in charge to decide whether to have an abortion or not, it's all in hands of God - he gives life and also terminates it whether you believe or not - you must not allow to kill unborn babies in the name of the law!
I am not an NHS service provider.
I never had abortion and I believe that It is a bad thing.
I never had abortion and I believe that it is a bad thing.
Mental health in the long term.
N/A
I am not sure. I imagine that if things go wrong, paramedics, G.P.s or community midwives may have extra work to do.
Again, this would need to be extracted from NHS statistics but I can imagine that there could be increase in GP or hospital appointments related to incorrect abortion pill self-administration and medical consequences of it.
N/A
I do not possess insight into this.
No
Unknown.
No.
No experience of this
None
Absolutely not, our now temporary service has reduced inpatient beds, surgical services this is because women feel more confident to deal with their abortion in their own home, personally I think we are giving much more information/guidance/support to give the women the confidence to cope in their own home. We have cancelled our regular general anaesthetic slots as, theses were just no being used. We have outsourced those that require this

treatment if high gestation or choice, we also are able to use emergency surgical slot on the Gynaecology ward if available. We now use less out-patient clinical staff and the Gynaecology nurse practitioners and clinicians and one health care support worker. We have been moved since March (2019) to CRI primary care where facilities are perfect for us as, we can provided 'there and then' contraception and we are working in collaboration with SH staff well with IUS/IUCD referrals. We have adequate rooms and triage facilities there and those women/girls that have to attend are able to safely distance in accordance with Covid guidelines. I am concerned that when we move back to UHW, we may not have these facilities and the service may revert back to what it was therefore, longer waiting times/unsafe distance/contraception/safe triage space.
No - BPAS data from April – July 2020 shows that complications for Early Medical Abortions declined compared to the same period in 2019. The risk of continuing pregnancy after treatment fell by three-quarters to 0.28%, down from 1.12% - potentially as the result of women being able to choose the best time for them to start the procedure, rather than having to fit it around their commitments in addition to the in-clinic appointment for the first medication • The same data shows that the risk of major complication (usually the only kind of complication that need hospital care) fell by 2/3rds from 0.09% to 0.03% • Existing DHSC provisions ensure that independent abortion care providers (who provide roughly 75% of all abortion care in England) provide follow-up care for women who access care with them. They have 24-hour aftercare phone line staffed by trained clinical staff, they provide in-clinic appointments for women with suspected incomplete abortions or retained products of conception, and they provide post-abortion counselling where a woman requires it. Telemedicine has not changed this. • The reduction in gestation means more women are able to access early medical abortion, reducing the need for surgical services and releasing capacity for other medical procedures
BPAS data from April – July 2020 shows that complications for Early Medical Abortions declined compared to the same period in 2019. T
The temporary approval has enabled hard-pressed clinical staff to concentrate on other aspects of providing medical care.
None
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Physical therapy.
Positive affect • BPAS data from April – July 2020 shows that complications for Early Medical Abortions declined compared to the same period in 2019. The risk of continuing pregnancy after treatment fell by three-quarters to 0.28%, down from 1.12% - potentially as the result of women being able to choose the best time for them to start the procedure, rather than having to fit it around their commitments in addition to the in-clinic appointment for the first medication • The same data shows that the risk of major complication (usually the only kind of complication that need hospital care) fell by 2/3rds from 0.09% to 0.03% • Ensure that independent abortion care providers provide follow-up care for women who access care with them. They have 24-hour aftercare phone line staffed by trained clinical staff, they provide in-clinic appointments for women with suspected incomplete abortions or retained products of conception, and they provide post-abortion counselling where a woman requires it. Telemedicine has not changed this. • The reduction in gestation means more women are able to access early medical abortion, reducing the need for surgical services and releasing capacity for other medical procedures
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No
N/A
BPAS data from April – July 2020 shows that complications for Early Medical Abortions declined compared to the same period in 2019. The risk of continuing pregnancy after treatment fell by three-quarters to 0.28%, down from 1.12% - this might have been the result of women being able to choose the best time for them to start the procedure, rather than having to fit it around their commitments in addition to the in-clinic appointment for the first medication. The data also shows that the risk of major complication = usually the only kind of complication that need hospital care - fell by 2/3rds from 0.09% to 0.03%. The reduction in gestation means more women are able to access early medical abortion, reducing the need for surgical services and releasing capacity for other medical procedures. In Wales, some services operate with only one doctor – meaning that women had previously needed either to attend the clinic repeatedly, or attend another service such as GP to obtain the first signature necessary for legal abortion care. Telemedicine has enabled services to undertake this activity behind the scenes, reducing pressure on other services both inside and outside hospitals.
No
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It is my understanding that all Welsh services have profited and that waiting times are reduced everywhere.
I am not aware of any other service being affected by this temporary service. however I would expect that many GP services would have been more involved with patient care.
No comment
We are all aware that the incidence of domestic violence and abuse has increased during lockdown. The temporary approval of home abortion removes one route for women to try to find a way out of their troubles.
Mental health services
Not able to comment
As both general complications and major complications have fallen, this reduces the strain on an overstretched NHS allowing it to focus more on other areas.
The measure has been helpful for single doctor practices in rural Wales making getting two signatories more efficient.
Thus has not been proven. However, the reduction of gestational age and the convenience of telemedicine have resulted in more medical treatments. Thus additional capacity for surgery was created as well as additional beds. The latter is a consequence of reduced gestational age and less need for inpatient medical treatments
Not that I am aware of

I'm not in a position to know.
Complications have reduced, which has reduced the number of women needing to be admitted or have a surgical procedure. Also, the average gestation length has decreased also meaning that fewer women need a surgical abortion.
-
I have accessed NHS services as normal, I have seen my GP and been for an ultrasound at hospital and blood tests with no delays or changes except masks and social distancing.
There is more increased accessibility in some areas that should have already been there. Counselling and therapy sessions online should already have been possible for people who needed it. Gender Services sessions for transgender people who need them should already be accessible online. There are people who would not have been able to access these services otherwise. And there are people who would have had to find a way to travel, around Wales' terrible transport framework, spend money (to travel and to stay the night perhaps!) when they should not have to spend this extra money if it's difficult for them, while others wouldn't have that money to spend.
Not negatively. It has freed up services.
Don't know
All. Including mental health.
Nac ydy.
Not sure
No.
The whole of the national health is falling apart because of mismanagement and bowing to everyone
Some 3% of women who take abortion pills up to 9 weeks' gestation will need surgical treatment for an incomplete abortion, according to BPAS. This increases to 7% of women for those whose pregnancy is between 9-10 weeks' gestation. The abortion provider is not the one managing these complications.
I feel sorry for the staff who destroy the unborn but have no personal experience of the effects of current actions. Covic 19 is already causing problems enough for our health professionals but personally I have had no problems with the NHS in Wales.
Some 3% of women who take abortion pills up to 9 weeks' gestation will need surgical treatment for an incomplete abortion, according to BPAS. This increases to 7% of women for those whose pregnancy is between 9-10 weeks' gestation. The abortion provider is not the one managing these complications.
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Check with the A and E stats of women attending with complications after use of the 2 abortion pills .
I am not employed in this area so am not able to comment.
-
I don't know
I have no knowledge by which I can answer this question.
Some 3% of women who take abortion pills up to 9 weeks' gestation will need surgical treatment for an incomplete abortion, according to BPAS. This increases to 7% of women for those whose pregnancy is between 9-10 weeks' gestation. The abortion provider is not the one managing these complications.
According to BPAS, about 3% of women who take abortion pills up to 9 weeks' gestation will need surgical treatment for an incomplete abortion. This increases to 7% for those whose pregnancy is between 9-10 weeks' gestation. The abortion provider is not the one managing these complications (words lifted from a sample letter on Christian Concern's website)
It has allowed us to use more staff within sexual health and not just pregnancy advisory. I don't see any impact on any other service which is negative.
NA
Midwifery, EPAU and Gynaecology services will have all been affected by the temporary approval. Reducing the number of service users requiring appointments or inpatients.
I do not know.
Not in my experience.
I have no experience of how other services have been affected.
I understand that a percentage of women have had to access A&E departments with complications like failure to fully abort the baby which puts pressure on NHS services.
BPAS data shows that the risk of major complication that needs hospital care fell from 0.09% to 0.03%. This has reduced the need for surgical services and released capacity for other procedures.
I have had no contact with any nhs services so cannot say
dont know
The abortion provider is not the body that picks up the management of complications associated with remote abortion. Thus other services will be affected by this.
Some 3% of woman who take abortion pills up to 9 weeks gestation will need surgical treatment for an incomplete abortion. There is a danger of excessive bleeding and I believe there has been a death.
I do not have the information necessary to answer this question.
I do not have experience of this.
I have not accessed contraceptive or abortion services in 2020, so I don't know.

I do not know.
Some 3% of women who take abortion pills up to 9 weeks' gestation will need surgical treatment for an incomplete abortion, according to BPAS. This increases to 7% of women for those whose pregnancy is between 9-10 weeks' gestation. The abortion provider is not the one managing these complications.
BPAS has stated that 3% of women who take abortion pills up to the nine week gestation period will require treatment for an incomplete abortion. This number increases to 7% of women wear their abortion takes place between nine and 10 weeks gestation. This is not handled by providers of the abortion pills but adds to the work of the NHS.
No
there has been less need to utilise early pregnancy and gynaecology services because we have seen fewer complications as women are being treated at earlier gestation. Services have also been helped by the introduction of the Frisky wales website which means that women can undertake a postal sexual health screen prior to their attendance at the service or treatment
I don't know.
I don't know
Accident and emergency departments are affected as they see the women who have complications who are not followed up by the abortion clinics. Complications are not being documented and followed up. Abortion by pills is not without complications. Concerns have been raised by Senior midwives who are aware of cases with complication in their area including deaths. https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Misc-Judicial-Review-Abortion-200729-NHS-email-2.pdf Abortion clinics do not provide follow up – women are expected to carry out their own self-assessment. If women have complications they go to A+E so these complications are not evident to the abortion providers resulting in a lack of clarity as to the real rate of complications. A+E departments are already under pressure and are not a suitable environment for a women suffering from complications from a home abortion.
I amnot practising now so cannot answer this question
Do not know
None
Surgery may bee needed if the abortion is incomplete, leading to an emergency situation.
Not that I am aware of but I can only assume if a home EMA has complications then medical professionals will be needed and therefore they may need to be taken from other important services if demand is high.
Of RCN Wales members asked, they had not experienced any effects of the temporary approval on other NHS Wales services.
Some 3% of women who take abortion pills up to 9 weeks' gestation will need surgical treatment for an incomplete abortion, according to BPAS. This increases to 7% of women for those whose pregnancy is between 9-10 weeks' gestation. The abortion provider is not the one managing these complications
I imagine that in time the mental health services will be affected, when women are struggling with what they have done in regret .
Some 3% of women who take abortion pills up to 9 weeks gestation will need surgical intervention for an incomplete abortion, according to BPAS. This increases to 7% for those whose pregnancy is 9 - 10 weeks gestation. The abortion provider is not the one who manages these complications.
Freedom of Information requests in other parts of UK indicate increased calls to ambulance services and visits to NHS hospitals by women who have taken EMA medication at home. Unaware of whether any FoI requests made in Wales. (Information given to women by abortion providers recommends them to go straight to their nearest NHS hospital if they have concerns following the procedure.)
I'm sure emergency services are the ones picking up the complications after problems taking the pills
I have no idea
more than likely they have, due to the potential of increased risk of premature births, higher risks of mental health problems and or complications such as haemorrhaging.
Early evidence from FOI requests to hospitals shows that complications resulting from incomplete medical abortions are being treated in hospitals. It is clear from the results of a mystery client survey (https://percuity.blog/mystery-client-survey/) that women are being told to present themselves to an emergency department if they are bleeding too much. As well as hospitals having to treat actual complications, the NHS will also be the ones dealing with women calling up with any concerns as they self-assess the progress of the abortion. All this means a shift of responsibility from abortion clinics to other NHS services.
According to reports in the press, some women have to call the ambulance service / report to A and E departments and then have surgical procedures, due to incomplete abortions. These elements are left to N.H.S. Wales and not the abortion providers.
I have no experience in that area.
See Q 2
An increase in A&E admissions where there have been complications
There have been increasing admissions to hospitals of women suffering from complications arising from taking abortion pills. These complications include haemorrhage, sepsis, and uterine perforation. These complications are more common with later gestational age, but there is no way to clinically check the gestational age with telemedicine. These complications put pressure on the NHS to treat these women who have normally been discharged by the abortion provider. Some 3% of abortion pill patients require surgical treatment to complete their abortion at up to 9 weeks. This rises to

7% for 9-10 weeks. This equates to hundreds of women requiring hospital treatment after taking abortion pills. https://www.plannedparenthood.org/learn/abortion/the-abortion-pill Evidence from Freedom of Information Requests summarised in a report published by Christian Concern shows: https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Briefings-Report-Hospital-Treatments-Complications-DIY-Abortion-210215.pdf 1. Every month some 495 women attend hospital with complications arising from abortion pills failing to complete the abortion. 250 of these women require hospital treatment to surgically remove retained products of conception. 2. 36 women make 999 calls every month seeking medical assistance for complications arising from taking abortion pills. Emergency calls relating to this were 54% higher in 2020 than in 2019. Ambulance responses were 19% higher than in 2019, even though ambulance responses in general were down 25% due to lockdowns. 3. The Care Quality Commission investigated 29 serious incidents where women accessing early medical abortion had suffered complications. 17 of these women had used the pills-by-post process. 4. The Care Quality Commission is investigating 11 cases where complications arose after abortion pills-by-post were taken when the gestational age was beyond the legal limit of 9-weeks-6-days. This shows that the use of pills-by-post abortion is increasing the burden on NHS Wales as more emergency calls and emergency treatment is required.
I think that there is evidence that women have needed help when their health has been threatenned aborting at home when of greater than expected gestation. It seems likely that care of women has not been attended to when they can not be seen to more fully assess their mental state and peaceful resolve without coercion.
No experience to judge
• BPAS data from April – July 2020 shows that complications for Early Medical Abortions declined compared to the same period in 2019. The risk of continuing pregnancy after treatment fell by three-quarters to 0.28%, down from 1.12% - potentially as the result of women being able to choose the best time for them to start the procedure, rather than having to fit it around their commitments in addition to the in-clinic appointment for the first medication • The same data shows that the risk of major complication (usually the only kind of complication that need hospital care) fell by 2/3rds from 0.09% to 0.03% • The reduction in gestation means more women are able to access early medical abortion, reducing the need for surgical services and releasing capacity for other medical procedures • In Wales, some services operate with only one doctor – meaning that women had previously needed either to attend the clinic repeatedly, or attend another service such as GP to obtain the first signature necessary for legal abortion care. Telemedicine has enabled services to undertake this activity behind the scenes, reducing pressure on other services both inside and outside hospitals
No
I have no personal experience, but I imagine anything that takes the strain off other NHS services can only be a good thing.
I don’t have enough information to answer this question.
No personal experience but data indicates that telemedicine has relieved pressure on other services.
I don't know. NHS healthcare professionals will not be satisfied with this service as they know women are not properly assessed safely. Costs may be reduced with telemedicine abortions, but this is not worth the lack of due care and the compromising of safety, with possible complications. Professionals know that they won't be able to assess the gestation age with any degree of certainty, or the medical history of the woman. Cost savings should not be allowed to weigh more heavily than ensuring that each woman is properly assessed, and has an opportunity to talk to a trained counsellor before giving her consent.
I have no knowledge of this
Don't know
Abortions declined compared to the same period in 2019. The risk of continuing pregnancy after treatment fell by three-quarters to 0.28%, down from 1.12% - potentially as the result of women being able to choose the best time for them to start the procedure, rather than having to fit it around their commitments in addition to the in-clinic appointment for the first medication • The same data shows that the risk of major complication (usually the only kind of complication that need hospital care) fell by 2/3rds from 0.09% to 0.03% • The reduction in gestation means more women are able to access early medical abortion, reducing the need for surgical services and releasing capacity for other medical procedures • In Wales, some services operate with only one doctor – meaning that women had previously needed either to attend the clinic repeatedly, or attend another service such as GP to obtain the first signature necessary for legal abortion care. Telemedicine has enabled services to undertake this activity behind the scenes, reducing pressure on other services both inside and outside hospitals
Unable to comment.
No. There are, in fact, markedly fewer complications requiring NHS care, which probably relates to the earlier and prompter service provided by telemedicine.

No, not in any negative way certainly.
Only benefits
No knowledge of this.
Not in my experience.
I don't know
Yes we have alleviated the pressure on our acute services by keeping patients requiring abortion care away from secondary care service providers. Prior to the temporary approval and the associated changes in remote abortion care, our patients were waiting longer and therefore being seen at later gestations. For this reason some of our patients were unable to access EMA and were reliant on inpatient hospital management. These numbers have decreased significantly since March 2020, releasing the hospital beds for other acute services.
I do not know.
Some 3% of women who take abortion pills up to 9 weeks' gestation will need surgical treatment for an incomplete abortion, according to BPAS. This increases to 7% of women for those whose pregnancy is between 9-10 weeks' gestation. The abortion provider is not the one managing these complications.
I don't know. This massive change is not a mere pragmatic question.
No Data from April – July 2020 shows that less follow up care is needed for complications of abortion following the change in regulation. This is because: ● Complications for Early Medical Abortions declined compared to the same period in 2019. The risk of continuing pregnancy after treatment fell by three-quarters to 0.28%, down from 1.12% - potentially as the result of women being able to choose the best time for them to start the procedure, rather than having to fit it around their commitments in addition to the in-clinic appointment for the first medication. ● The risk of major complication (usually the only kind of complication that need hospital care) fell by 2/3rds from 0.09% to 0.03%. The reduction in gestation means more women are able to access early medical abortion, reducing the need for surgical services and releasing capacity for other medical procedures.
Evidence shows home use of mifepristone does not have increased rates of complications. Therefore, this temporary measure will not increase the burden on NHS services. In fact, it will save NHS Wales money and therefore could improve other services!
Not in my experience
Mae data BPAS yn dangos bod erthyliadau wedi bod yn digwydd yn gynt yn beichiogrwydd, sy'n golygu bod pethau'n fwy diogel ac mae llai o risg o gymhlethdodau meddygol. Mae'r drefn bresennol yn cymryd llai o amser staff a doctoriaid o wneud sawl apwyntiad, felly mae wedi rhyddhau capasiti staffio ar gyfer gwaith arall yn y gwasanaeth iechyd.
Not to my knowledge.
I understand there have been numerous medical emergencies resulting in women being taken to hospital following a medical abortion at home since March 2020. I also know there will be increased pressure on our mental health services.
No direct experience - have A&E departments had to deal with complications?
NHS hospitals have seen increasing numbers of women presenting with complications after self-administering the abortion pills. During the telemedicine consultations women are instructed to go to their local A&E department immediately if complications arise; these include haemorrhage, sepsis, and uterine perforation. The risk of such complications increases with increasing gestational age and there is an acknowledgment by the abortion organisations that some women are understating the gestational age of their pregnancy when obtaining the abortion pills for use at home. Our NHS hospitals are needing to look after these women, since in effect they have been discharged by the abortion provider as soon as the treatment pack is posted. Please see our full report on FOI responses from the CQC and the NHS related to complications arising from medical abortions at home: https://percuity.files.wordpress.com/2021/02/complications-from-ema-kd210211.pdf
Providers have reported that the number of women self-referring to abortion services has increased. Self-referral was a key recommendation in the NICE/RCOG best practice abortion care guidance issues in 2019, and reduced demand on other areas of the health system (e.g., general practice).
No
This has reduced the footfall of patients attending the DOSH clinic where I work, which is better for patients and staff.
Yes. It has reduced the pressure on other services provided by the NHS
Some 3% of women who take abortion pills up to 9 weeks' gestation will need surgical treatment for an incomplete abortion, according to BPAS. This increases to 7% of women for those whose pregnancy is between 9-10 weeks' gestation. The abortion provider is not the one managing these
Some 3% of women who take abortion pills up to 9 weeks' gestation will need surgical treatment for an incomplete abortion, according to BPAS. This increases to 7% of women for those whose pregnancy is between 9-10 weeks' gestation. The abortion provider is not the one managing these complications.

Mental health services and crisis teams are already stretched but they may also be affected more if complications lead to trauma and suffering.
The Aiken cohort study (https://dx.doi.org/10.2139/ssrn.3742277) has found that there was no difference in outcomes between the previous pathway and the new, telemedical pathway. This includes no increased risk of serious adverse events which would require hospital care (0.04% in the previous pathway, compared to 0.02% in the new pathway), and indeed a slight increase in success rates (98.2% compared to 98.8%) which would likely have a positive impact on NHS abortion services. The evidence we have heard from Welsh abortion providers is that they are providing fewer Evacuation of Retained Products of Conception procedures – reducing the length of surgical lists and minimising the number of women who have to present to gynaecological services. The administrative changes that the temporary approval has allowed for have also created positive effects for NHS Wales Service. Some abortion services in Wales operate with only one doctor, in these instances women were previously either required to attend the clinic repeatedly or attend another NHS services, such as their GP, to obtain the first signature for her HS1A form. However, telemedicine has allowed the sourcing doctors signatures to happen behind the scenes, creating more capacity for doctors and clinicians, relieving pressure on GPs and creating more time for them to see other patients.
Other services have not been affected as there has been no rise in complications of early abortion or in major complications. Earlier gestation has undoubtedly been important in this factor.
Before the approval of mifepristone at home, thousands of women in Wales were passing their pregnancies at home. Even prior to the approval for the home use of misoprostol, women were not remaining in hospital to pass their pregnancy, but instead travelling home often while suffering the early stages of miscarriage. Complications in need of healthcare support are disproportionately likely to happen at this stage rather than in the early The large cohort study (https://doi.org/10.1111/1471-0528.16668) found that there were no differences to complications after the change to telemedical abortion care, and indeed that some of complications which may require further abortion service involvement such as continuing pregnancies had declined. As a result, there is absolutely no reason to suggest that there has been a wider impact on NHS Wales services as a result of the change. More broadly, telemedicine has been accompanied by self-referral into abortion services in a number of areas where this was not already in place, including in Welsh Health Boards. This means that there is less pressure on sexual health, contraceptive, and GP services which may previously have been required to refer patients into the abortion service – or to provide signatures for the HSA1 prior to treatment taking place. At least one Welsh Health Board has been able to stop requiring either referral from a local GP or having to delay care for clients as a result of being able to provide HSA1 signatures between a telephone consultation and the dispatch of abortion medication – reducing the pressure on wider healthcare services.
Some 3% of women who take abortion pills up to 9 weeks' gestation will need surgical treatment for an incomplete abortion, according to BPAS. This increases to 7% of women for those whose pregnancy is between 9-10 weeks' gestation. The abortion provider is not the one managing these complications
All Welsh Health Boards have seen an improvement in the abortion services that they have been able to provide due to the temporary measures.
I have no intimate knowledge to answer this question, but suggest it might well free professional's time for other O and G work
I am unsure whether there has been any direct effects, but I think it is important to note here that the British Pregnancy Advisory Service (that provides the majority of abortions in England and Wales) has its own 24/7 aftercare hotline to assist clients who may need additional help.
This has been detrimental for women in wirral NHS services, so the issues are unlikely to be any different in NHS wales.
3% of women taking these drugs will need surgical intervention (7% if taken between 9 & 10 weeks). This will impact on an NHS service already under extreme pressure due to covid 19.
As over 96% of all north welsh terminations are carried out in England it will have had minimal effect on the welsh NHS other that the continued siphoning off of welsh NHS funds to outside of wales and the welsh economy
Don't know.
Some 3% of women who take abortion pills up to 9 weeks' gestation will need surgical treatment for an incomplete abortion, according to BPAS. This increases to 7% of women for those whose pregnancy is between 9-10 weeks' gestation. The abortion provider is not the one managing these complications.
I have no way of telling as I do not live in Wales.
I am not aware of any benefits to other services though the provision of home abortion.
According to BPAS, some 3% of women who take abortion pills up to 9 weeks' gestation will need surgical treatment for incomplete abortions. This increases to 7% of women for those whose pregnancy is 9-10 weeks along. The abortion provider does not manage these complications - these women are sent to NHS hospitals for treatment.
I don's have experience to comment on this.
No experience.
I have read that 3% of women who take abortion pills up to 9 weeks' gestation will need surgical treatment for an incomplete abortion, according to BPAS. This increases to 7% of women for those whose pregnancy is between 9-10 weeks' gestation. The abortion provider is not the one managing these complication, NHS Wales is.
No evidence
Don't know
Freedom of information requests have revealed that abortion providers are charging the NHS £77 per phone consultation and £344.80 for the abortion pills in North Wales. So the 46,000 at home abortions that have occurred

under the temporary legislation will cost the NHS roughly £19.4 million excluding additional costs from women needing emergency services and mental health services from abortion. All of this while overhead costs for abortion clinics do not need to be maintained, allows abortion services to profit massively from the legislation at the expense of the NHS and women's wellbeing. What is also of concern is that whilst women are told by the service providers to expect some amount of blood during the medical abortion, there is no way for the woman to know whether the loss of blood she is experiencing is the expected amount. If it results in the woman bleeding excessively, this allows the risk of infections and haemorrhaging to take place, with the woman needing care medical treatment only the NHS can provide.
I am not in a position to comment on this.
It would seem obvious that other NHS Wales Sevices will be impacted . The administration of this temporary service may be added to an already stretched department. There will be an increase in the number of cases being dealt with in Emergency Depts, and Ambulance Service as women are advised by abortion providers to contact these Services in the event of experiencing concerns regarding any complications. Treating these consequences of DIY home abortions may take medical professionals away from fighting COVID19 at a time when Hospitals are under severe pressure
I think they have benefited as less staff have been needed for abortion services
Unable to comment.
I don't know. Most healthcare professionals will not be satisfied with these services as they know women cannot be properly or safely assessed by telephone to ensure that they are eligible for the abortion treatment at home. Costs may be reduced with telemedicine abortions, but this is not worth the lack of due care and compromising of safety, with possible complications.
Some 3% of women who take abortion pills up to 9 weeks' gestation will need surgical treatment for an incomplete abortion, according to BPAS. This increases to 7% of women for those whose pregnancy is between 9-10 weeks' gestation. The abortion provider is not the one managing these complications.
N/A
Data from April – July 2020 shows that less follow up care is needed for complications of abortion following the change in regulation. This is because: - Complications for Early Medical Abortions declined compared to the same period in 2019. The risk of continuing pregnancy after treatment fell by three-quarters to 0.28%, down from 1.12% - potentially as the result of women being able to choose the best time for them to start the procedure, rather than having to fit it around their commitments in addition to the in-clinic appointment for the first medication. - The risk of major complication (usually the only kind of complication that need hospital care) fell by 2/3rds from 0.09% to 0.03%. The reduction in gestation means more women are able to access early medical abortion, reducing the need for surgical services and releasing capacity for other medical procedures.
1) Medical abortion under the temporary measure means other NHS services could have been affected by women being less sure of any complications they experience and so access NHS services more often either due to more severe complications than with a clinic appointment or uncertainty on their condition. For example, abortion pills taken after 10 weeks' gestation could mean an increase in ambulance call outs for incomplete abortion. Abortion providers will not know of the rate of complications once they have sent pills in the post but other NHS services will have this on record at their expense.
This is an area that would benefit from research but it is hard to imagine any way in which the temporary approval could have anything other than an overall positive impact - because earlier gestation abortion means less complication. Ectopic pregnancy diagnosis can at the worst be diagnosed at same rate - but may in fact be picked-up ealrlier with these news ways of offering care. Services have had to learn differences but the overall impact feels enormously positive and reduces workload elsewhere.

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.

dk
Women should be offered proper advice and not selective information,they should be told everything that happens in an abortion whether it's in person or over the phone.
Missing an ectopic pregnancy. If a woman is only having a consultation over the phone, an ectopic pregnancy can be missed. Ectopic pregnancy is life-threatening and women should not take abortion pills. Abortions carried out with medical supervision are as equally wrong as abortions carried out with no medical supervision. However, for the purpose of this consultation I want the Government to be fully aware of the dangers to women from home abortions.
An ectopic consultation can be easily missed without a visit to a clinic. Ectopic pregnancy is life-threatening and women should not take abortion pills if they have this condition. Taking abortion away from a medical setting means that abusive partners can coerce women into having an abortion. Remote abortion takes away the opportunity for a healthcare professional to detect domestic abuse.
This is a leading question, as no doubt it is intended to be. If the medical advice is for termination, it is always the wrong advice anyway. Deciding to kill one of the patients is an abdication of responsibility. You cannot simultaneously safeguard a woman's safety, whilst approving the immediate death by dismemberment or poisoning of a new human being, at least half of whom will be female. The best way of safeguarding a woman's health, the health of the majority of women who presently come into existence, is not to make her mother take a pill and destroy her. Yet, if a clinician can sincerely and effectively promote another treatment than abortion for an unexpected or inconvenient pregnancy, then, yes, a visit might be useful. Otherwise, attempting an abortion at home, and failing, and then changing one's mind, might prove a better option for both human beings concerned, although still horrific in contemplation.
YES, at least one visit. Only a clinician or other qualified medical practitioner can carry out a proper medical examination of the woman -- who could detect an ectopic pregnancy if there is one. Only face-to-face consultation with a fully-qualified medical practitioner can ascertain accurately the family circumstances of the woman ; e.g. whether she is under the control of an abusive partner.
Usually when a Woman has self-referred, if we are unable to contact the by telephone or video link, we usually will look at clinical history or previous safeguarding issues, which would be a trigger. The triage process is a good time to ask appropriate safeguaring questions and is in any doubt (best judgement), always bring those Women in for `face to face` review.
No. I think this step effectively restricts access to services, delays early abortion into a later and more problematic phase, and exposes women to stigma and shame
Provided the option of attendance at a clinic once or twice as a matter of choice is retained, there should not be a problem.
It is well to be sure the process is complete and that there are no incomplete products of conception still in the uterus.
see Q1 above
There are risk to women carrying out a DIY abortion without visiting a clinic. Missing an ectopic pregnancy, Domestic abuse, and missing the opportunity to detect domestic abuse. Where as the pregnancy problem is self evident and life threatening to the mother, remote abortions also removes the opportunity for a healthcare professional to detect domestic abuse. Women are given no opportunity to discuss their pregnancy confidentially with a doctor.
I absolutely think there are benefits to women in visiting somewhere to see a clinician prior to having an abortion. At the very least just to ensure that they know what they are committing to, what they will have to do and what might happen as a result of it.
There should be not just clinical but emotional support given to a mother, and a thorough discussion about all options, not just the option of abortion, but help in parenthood and if necessary, adoption for the unplanned child.
What if it is an ectopic pregnancy? Partner's domestic abuse if trying to force woman to take pill which is likely to go undetected
Sorry but I dont agree with any of this.. its murder no matter how you make it look
As listed above. This makes abortion seem an every day occurrence and will increase abortions. The law regarding access to abortion based on certain circumstances cannot be assessed properly. Women unable to receive health checks before taking drugs. No assessment for situations like eptopic pregnancies. Women could retain ‘products of conception’ (the child) and fall ill, even die and no one will have monitored her during the process from beginning to end.
It is easier to detect domestic abuse and coercion to have an abortion in a face to face consultation which should happen in every case, not over telephone.
Definitely! It is essential that women contemplating abortion have access to a counsellor. The desire for abortion can often be covering deeper emotional problems which the woman could have addressed in a far less traumatic way.
Benefits to seeing a clinician would be that ectopic pregnancies can be diagnosed and wont be missed, these can be life threatening. Domestic abuse victims would be more likely to speak up of they saw a clinician or doctor face to

face and outside of the home environment. Removing abortion from the medical setting increases the opportunity for abusive partners to force women into abortion.
There are no benefits. Women who are considering an abortion need counselling, so that they can give birth to their child.
Better availability of advice and support to continue pregnancy in clinical visits Better risk management Better assessment of woman's needs, Abortion shouldn't be as simple as making a call and getting some pills. Lives and mental well-being are on the line and women and children deserve better care overall.
Yes, the more visits the better. They need time to think about the implications and the utter seriousness of what they are undertaking. More ultrasounds needed so they can see whose life they are about to end.
Yes. It is easier to detect domestic violence and Intimate Partner Violence when a woman attends a clinic in person. Body language and physical symptoms can be picked up, which are not able to be picked up over the phone. Making a woman attend a clinic before obtaining abortion medication will ensure that she has had the chance to discuss termination with a clinician on her own, away from any coercive influences, and without any duress. This simply cannot be ensured when speaking to her over the telephone. Women can give false information, for example, regarding the medication they are taking, or their pregnancy's gestation, which can lead to serious complications from taking the abortion pills. It is much less likely or possible for women to give false information when they attend a clinic in person. A woman's identity could be verified at the clinic, for example, by asking her to bring ID to her appointment, and her gestation can be verified by means of an ultrasound scan. The ultrasound scan would also determine the location of her pregnancy, ie whether it is intrauterine or ectopic. Skipping these steps could be dangerous for women. Allowing women to obtain abortion pills without the clinic visit is dangerous and opens up the process to all sorts of abuses.
There are some extremely important reasons why a woman carrying out a DIY abortion should visit a clinic before proceeding. Correct gestation can be assessed on consultation as well as the risk of ectopic pregnancy. A clinician can also assess the emotional health of a woman and detect signs of domestic abuse.
Yes. A women's physical, emotional and mental health and wellbeing can to some extent be assessed by a face to face consultation with an experienced clinician.
I would have thought it obvious. Should that question really have to be asked ?
Yes I believe there are benefits in relation to safeguarding and women's safety requiring them to make at least one visit to a service to be assessed.
Yes Risks to women carrying out a DIY abortion without visiting a clinic include missing an ectopic pregnancy. Missing an opportunity to detect domestic abuse. Removing the provision of abortion pills from a medical setting increases the opportunity for abusive partners to force women into have abortions.
Yes indeed. - human contact is essential since this is a life and death situation.
If the woman concerned has access to a clinician then she can share whether or not she WANTS to dispose of the foetus, whether she would like to keep it but is being forced into losing it, or if she is forced to be used for illicit sex by an abuser or that the male who impregnated her has some sexual disease etc
Undoubtedly. A woman who is a victim of domestic abuse has a markedly better chance of being identified and helped if she attends a clinic than in a telephone conversation. Remote consultations takes away the opportunity for a clinician to detect abuse. Domestic violence is a noted and recognised factor in abortion worldwide. There is also the risk that other problems, such as life threatening ectopic pregnancy, may be present and missed.
instead of putting all your time and resources towards harmful abortion clinics, who kill babies... please concentrate and allocate other clinicians away from Covid drama and propaganda as more people die today from neglect or ignorance of the services than from the virus itself - it's an excuse for all failures these days! wake up Welsh gov. and start treating people who really need your help like people suffering from cancer and other similar disorders...
I think all women should be assessed by a clinician to ensure safeguarding. Terminations may be a simple medical procedure but can, for some women, have long lasting psychological consequences. Some women may also be under-pressure, coerced, bullied into having a termination and there should be safeguards in place to protect those vulnerable women. A telephone consultation is not sufficient, there may be someone with the women who prevents her from speaking freely and may even have instigated the procedure.
Risks to women carrying out a DIY abortion without visiting a clinic include: • Missing an ectopic pregnancy. If a woman is only having a consultation over the phone, an ectopic pregnancy can be missed. Ectopic pregnancy is life-threatening and women should not take abortion pills. • Domestic abuse is strongly associated with abortion. Removing the provision of abortion pills from a medical setting increases the opportunity for abusive partners to force women into having abortions. • Missing the opportunity to detect domestic abuse.
I think that abortion is not good.
I think that abortion is not good.
Yes Risks to women carrying out a DIY abortion without visiting a clinic include: • Missing an ectopic pregnancy. If a woman is only having a consultation over the phone, an ectopic pregnancy can be missed. Ectopic pregnancy is life-threatening and women should not take abortion pills. In a report from the American Food and Drug Administration, 97 ectopic pregnancies were reported after women took Mifepristone. The initial consultation had missed the ectopic pregnancy.6

• Domestic abuse is strongly associated with abortion. Intimate partner violence (IPV) is a risk factor for abortion all over the world.7,8,9,10,11, Removing the provision of abortion pills from a medical setting increases the opportunity for abusive partners to force women into having abortions. • Missing the opportunity to detect domestic abuse. Studies on domestic abuse have suggested that there should be greater efforts to ask women if they are subject to domestic abuse when they present for an abortion.12 Remote abortion removes the opportunity for a healthcare professional to detect domestic abuse. Women are given no opportunity to discuss their pregnancy confidentially with a doctor.
I believe it important for women to have a face to face consultation with a clinician before completing this process to make sure they are doing this for themselves and not being forced into something they don't want.
The experience of the pandemic shows that safeguarding risk assessment can be carried out remotely. Women experiencing domestic abuse may be put at greater risk by requiring them to make a visit to attend clinic, if they have not shared information about their pregnancy plans.
Absolutely. Decisions of this magnitude need to be made very carefully and with access to information about all possibilities . Clinicians need to assess both the physical and mental health of the mother and particularly the true extent of her pregnancy . A face to face consultation may save a baby's life. Life is precious. Mothers need to know that this is a human being not just an inconvenient mass of cells.
Definitely yes. For many woman decision to terminate pregnancy must be a very hard one to take and they need not only to discuss in confidence available options but find reassurance what help and where is available to them.
Yes Risks to women carrying out a DIY abortion without visiting a clinic include: • Missing an ectopic pregnancy. If a woman is only having a consultation over the phone, an ectopic pregnancy can be missed. Ectopic pregnancy is life-threatening and women should not take abortion pills. In a report from the American Food and Drug Administration, 97 ectopic pregnancies were reported after women took Mifepristone. The initial consultation had missed the ectopic pregnancy.6 • Domestic abuse is strongly associated with abortion. Intimate partner violence (IPV) is a risk factor for abortion all over the world. Removing the provision of abortion pills from a medical setting increases the opportunity for abusive partners to force women into having abortions. • Missing the opportunity to detect domestic abuse. Studies on domestic abuse have suggested that there should be greater efforts to ask women if they are subject to domestic abuse when they present for an abortion. Remote abortion removes the opportunity for a healthcare professional to detect domestic abuse. Women are given no opportunity to discuss their pregnancy confidentially with a doctor.
Yes, I believe it is beneficial for the safety of women to be assessed by a clinician at least once to help identify safeguarding issues, to provide reassurance to these women, to support them and to allow a safe space for these women to attend without worrying about their environment.
Yes: - see q. 1 and 3 above with regard to risk of coercion and abuse that need to be minimised - the danger of missing a possible ectopic pregnancy is higher in a purely online consultation.
No
No, EMA should not routinely require this.
Yes. Counselling and proper supervised care.
I've covered this in previous questions, but to reiterate, women with abusive partners may clearly be at risk .....women who don't realise the possible 'side effects' of an abortion, maybe are too worried to give them consideration would also benefit from one visit to a doctor (specifically a doctor). It's short-sighted to think that making abortion easier will be better for women. Well-documented problems including PID/difficulty conceiving in the future/resultant grief in some cases (which may well come out years later) and associated mental health issues (this is not a grief like others) all have their effect on a woman's well-being. Abortion should not be treated lightly and so there is real benefit to a woman being able to talk to a doctor. This raises the issue of abortion providers who do it for profit. The only women who I know who have gone to such places for help have not received impartial advice, more like, here's how you get an abortion fullstop.
No, there are no benefits of this. Telephone service is sufficient and necessary at all times
I am not a professional, but on a basic human level, it must be right to treat a woman as an individual with a range of needs, rather than simply a consumer, in making a decision as serious as terminating a pregnancy.
I tend to deal with a lot of Safeguarding in my area of work, I have to revert back again to the thorough triage, women/girls tend to open up about issues/situations they are in, whilst they are alone on video call or telephone, those that we have the slightest concern or something does not add up, then we communicate with safeguarding. The importance of asking the women/girl if she is safe to have a triage in her own home initially is important, if they are not then they attend clinic. All under 18's usually attend clinic for ultrasound unless clinician is satisfied with history. I feel safeguarding has drastically increased during Covid-19, in those cases it is always wise for these women to attend clinic and before this visit we can communicate with other agencies to gather available information. One benefit I feel now is that, we do not let the partner into clinic and women/girls tend to be freer with the information they give. 99% of women are happy to attend alone but, they are on the understanding this is Covid guidelines, however we allow a parent if there is a minor but, the parent usually will wait in the waiting area.

Given the potential difficulties in home situations and cultural factors or even awareness of what is involved then to require the involvement of a clinician is the most basic sensible safeguard a society should provide alongside the availability of serious medication.
No, there are disadvantages. Every woman is asked by abortion providers whether they are safe at home. This is a routine part of abortion care, no matter how or where care is provided. • Some women seeking access to services are in relationships or home environments where their behaviour and travel are monitored – meaning travelling to an abortion clinic is difficult or dangerous. Telemedicine enables these women to access abortion care without risking their personal safety. • Women in difficult circumstances are now more likely to seek regulated care and support in the knowledge that they will not be forced to travel to a clinic to access that help – the online pill provider Women on Web, which frequently received requests from women in coercive or controlling relationships, reports these women are now able to access legal care. • Abortion services continue to provide in-person care where telephone consultations raise safeguarding concerns such as safety or privacy at home, ability to consent, or wider safety concerns surrounding existing children or statutory concerns such as Female Genital Mutilation • Abortion providers report that providing care remotely led to increases in the number of women disclosing problems at home. BPAS reported that in the first three months of their Pills by Post service, 10% of clients underwent an enhanced safeguarding risk assessment – a 12% increase compared to March 2020. • Clinicians providing abortion services report that telemedicine has made women more willing to disclose concerns about safety when in the privacy and familiarity of their own surroundings, as opposed to a clinical environment
Clinicians providing abortion services report that telemedicine has made women more willing to disclose concerns about safety when in the privacy and familiarity of their own surroundings, as opposed to a clinical environment.
No, I do not consider that there are any benefits in requiring women to make at least one visit to be assessed by a clinician in order to rubber-stamp their decisions.
Yes, as above, I think vulnerability assessments and the opportunity to offer counselling.
Every woman is asked by abortion providers whether they are safe at home. This is a routine part of abortion care, no matter how or where care is provided. For instance, one NHS service in Wales gives women a safe word in their first interaction so they can raise concerns in the event they are not able to find somewhere private to speak. • Some women seeking access to services are in relationships or home environments where their behaviour and travel are monitored – meaning travelling to an abortion clinic is difficult or dangerous. Telemedicine enables these women to access abortion care without risking their personal safety. • Women in difficult circumstances are now more likely to seek regulated care and support in the knowledge that they will not be forced to travel to a clinic to access that help – the online pill provider Women on Web, which frequently received requests from women in coercive or controlling relationships, reports these women are now able to access legal care. • Abortion services continue to provide in-person care where telephone consultations raise safeguarding concerns such as safety or privacy at home, ability to consent, or wider safety concerns surrounding existing children or statutory concerns such as Female Genital Mutilation • Abortion providers report that providing care remotely led to increases in the number of women disclosing problems at home. BPAS reported that in the first three months of their Pills by Post service, 10% of clients underwent an enhanced safeguarding risk assessment – a 12% increase compared to March 2020. • Clinicians providing abortion services report that telemedicine has made women more willing to disclose concerns about safety when in the privacy and familiarity of their own surroundings, as opposed to a clinical environment
Only if there are concerns that the woman is being forced or coerced into an abortion.
Disadvantages - Every woman is asked by abortion providers whether they are safe at home. This is a routine part of abortion care, no matter how or where care is provided. • Some women seeking access to services are in relationships or home environments where their behaviour and travel are monitored – meaning travelling to an abortion clinic is difficult or dangerous. Telemedicine enables these women to access abortion care without risking their personal safety. • Women in difficult circumstances are now more likely to seek regulated care and support in the knowledge that they will not be forced to travel to a clinic to access that help – the online pill provider Women on Web, which frequently received requests from women in coercive or controlling relationships, reports these women are now able to access legal care. • Abortion services continue to provide in-person care where telephone consultations raise safeguarding concerns such as safety or privacy at home, ability to consent, or wider safety concerns surrounding existing children or statutory concerns such as Female Genital Mutilation • Abortion providers report that providing care remotely led to increases in the number of women disclosing problems at home. BPAS reported that in the first three months of their Pills by Post service, 10% of clients underwent an enhanced safeguarding risk assessment – a 12% increase compared to March 2020. • Clinicians providing abortion services report that telemedicine has made women more willing to disclose concerns about safety when in the privacy and familiarity of their own surroundings, as opposed to a clinical environment
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instance, one NHS service in Wales gives women a safe word in their first interaction so they can raise concerns in the event they are not able to find somewhere private to speak. • Some women seeking access to services are in relationships or home environments where their behaviour and travel are monitored – meaning travelling to an abortion clinic is difficult or dangerous. Telemedicine enables these women to access abortion care without risking their personal safety. • Women in difficult circumstances are now more likely to seek regulated care and support in the knowledge that they will not be forced to travel to a clinic to access that help – the online pill provider Women on Web, which frequently received requests from women in coercive or controlling relationships, reports these women are now able to access legal care. • Abortion services continue to provide in-person care where telephone consultations raise safeguarding concerns such as safety or privacy at home, ability to consent, or wider safety concerns surrounding existing children or statutory concerns such as Female Genital Mutilation • Abortion providers report that providing care remotely led to increases in the number of women disclosing problems at home. BPAS reported that in the first three months of their Pills by Post service, 10% of clients underwent an enhanced safeguarding risk assessment – a 12% increase compared to March 2020. • Clinicians providing abortion services report that telemedicine has made women more willing to disclose concerns about safety when in the privacy and familiarity of their own surroundings, as opposed to a clinical environment
I do not believe there are many benefits to putting the requirement in place as the procedures are not demanding and do not necessarily require an in person consultation. I believe that each individual situation should be correctly evaluated to provide those that truly need to be assessed with the correct services for example if a clinician believes the patient needs to fully discuss the matter at hand before making any decisions then this service should be offered to them. Another example being if the patient is very young or seems unsure about what is right for them then they should also be offered a consultation.
Yes there are some benefits to ensure the woman is not under duress to terminate a pregnancy or using the option as a form of a contraception, however the overriding factor in this is that the woman has a right to decide what happens to her body, just as much as man does with a vasectomy.
No! Women are to be trusted to know their own bodies and respond accordingly.
Yes. It reduces the chance of them being coerced into unwanted abortions, and reduces the risk of inappropriate medication (for instance, if the pregnancy is more advanced than they admit or realise).
Every woman is asked by abortion providers whether they are safe at home. This is a routine part of abortion care, no matter how or where care is provided. For instance, one NHS service in Wales gives women a safe word in their first interaction so they can raise concerns in the event they are not able to find somewhere private to speak. Some women seeking access to services are in relationships or home environments where their behaviour and travel are monitored – meaning travelling to an abortion clinic is difficult or dangerous. Telemedicine enables these women to access abortion care without risking their personal safety. Women in difficult circumstances are now more likely to seek regulated care and support in the knowledge that they will not be forced to travel to a clinic to access that help – the online pill provider Women on Web, which frequently received requests from women in coercive or controlling relationships, reports these women are now able to access legal care. Abortion services continue to provide in-person care where telephone consultations raise safeguarding concerns such as safety or privacy at home, ability to consent, or wider safety concerns surrounding existing children or statutory concerns such as Female Genital Mutilation. Abortion providers report that providing care remotely led to increases in the number of women disclosing problems at home. BPAS reported that in the first three months of their Pills by Post service, 10% of clients underwent an enhanced safeguarding risk assessment – a 12% increase compared to March 2020. Clinicians providing abortion services report that telemedicine has made women more willing to disclose concerns about safety when in the privacy and familiarity of their own surroundings, as opposed to a clinical environment
Not unless there deems to be a need from the initial telephone triage
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There are benefits to a visit for some and benefits of no visit for others. For women in a situation of domestic violence the time of pregnancy is associated with the highest risk, so making abortion available at home without the need to arrange a hospital visit can be crucial. As above, developing a plan for these women through an MDT is important and can b e facilitated or at the very least is not reduced by tele medicine and action can be taken AFTER the pregnancy has ended which may be a safer time for her to engage with services in person.
there are many benefits to a women being assessed by a clinician. to firstly scan the women to ensure that there is no chance of an Etopic pregnancy, and that the pregnancy is no further than 9 weeks and 6 days. also this would ensure that the patients wellbeing is being taken into account, and that the women is making this decision herself and not being forced into a decision that she is not comfortable with. A patient may also benefit from having a follow up scan with a clinician to ensure the termination is completed with no lasting effects, at this time a counselling option could be offered to ensure the patients mental wellbeing is unaffected.
Yes. There are benefits for both safeguarding and safety. Women will be able to discuss their concerns in a safe, confidential environment. Clinicians can assess non-verbal feedback, confirm that the person requesting the medication is the one who is pregnant, and if necessary be able to verify the gestation and location of the pregnancy.
• Every woman is asked by abortion providers whether they are safe at home. This is a routine part of abortion care, no matter how or where care is provided. For instance, one NHS service in Wales gives women a safe word in their first interaction so they can raise concerns in the event they are not able to find somewhere private to speak. • Some women seeking access to services are in relationships or home environments where their behaviour and travel are monitored – meaning travelling to an abortion clinic is difficult or dangerous. Telemedicine enables these women to access abortion care without risking their personal safety. • Women in difficult circumstances are now more likely to seek regulated care and support in the knowledge that they will not be forced to travel to a clinic to access that help – the online pill provider Women on Web, which frequently received requests from women in coercive or controlling relationships, reports these women are now able to access legal care. • Abortion services continue to provide in-person care where telephone consultations raise safeguarding concerns such as safety or privacy at home, ability to consent, or wider safety concerns surrounding existing children or statutory concerns such as Female Genital Mutilation • Abortion providers report that providing care remotely led to increases in the number of women disclosing problems at home. BPAS reported that in the first three months of their Pills by Post service, 10% of clients underwent an enhanced safeguarding risk assessment – a 12% increase compared to March 2020. • Clinicians providing abortion services report that telemedicine has made women

more willing to disclose concerns about safety when in the privacy and familiarity of their own surroundings, as opposed to a clinical environment.
No comment
She should make at least one visit to a women's health professional before deciding on an abortion. This will give her the chance to consider her reasons for an abortion and discuss with the clinician that this the right decision or otherwise.
Abortion is not just a medical problem which can be solved by taking a pill. There are huge mental consequences of terminating life - even at an early stage which as a society we fail to understand and support. Even parents who suffer miscarriages at early stages of pregnancy are ignored and misunderstood. There is a fundamental trauma which is caused by the termination of life - whilst the woman might still choose to go ahead with this decision, we, as a society, have a duty of care to ensure that she understands the whole impact of that decision, rather than just present it as a medical procedure. An in-person visit also mitigates for instances where the woman may be vulnerable, abused or coerced.
Yes I think there are: Risks to women carrying out an abortion under these temporary measures without visiting a clinic include: • Missing an ectopic pregnancy. If a woman is only having a consultation over the phone, an ectopic pregnancy can be missed. Ectopic pregnancy is life-threatening and women should not take abortion pills. In a report from the American Food and Drug Administration, 97 ectopic pregnancies were reported after women took Mifepristone. The initial consultation had missed the ectopic pregnancy. • Domestic abuse is strongly associated with abortion. Intimate partner violence (IPV) is a risk factor for abortion all over the world. Removing the provision of abortion pills from a medical setting increases the opportunity for abusive partners to force women into having abortions. • Missing the opportunity to detect domestic abuse. Studies on domestic abuse have suggested that there should be greater efforts to ask women if they are subject to domestic abuse when they present for an abortion. Remote abortion removes the opportunity for a healthcare professional to detect domestic abuse. Women are given no opportunity to discuss their pregnancy confidentially with a doctor.
Yes - see above
Yes - this is a highly immotive subject and the person concerned needs all the objective in person help and support they can get to make the right decision - this should include access to pro life information. Quick and easy access to a pill is not the answer!
As stated above, by seeing a clinician your able to understand the person's understanding of complications, how mature they are and if they are actually doing it for themselves or for the right reason.
Majority of women don't need this. Should be considered in cases where notes are flagged for other reasons or in case of multiple referrals from one address.reserve the right to consult.
To speak to a professional who can outline properly the negatives alongside the positives has to be a proper safeguard which really ought to be treasured. For the woman to express herself to a professional must also be considered a very important aspect, especially over issues such as coercion or mental health.
Travelling to a clinic is much harder for some women who do not have full freedom of movement and the safeguards in place allow women to access this service more safely and more easily than they otherwise would should things return to requiring visits.
Welsh practitioners have been developing ways to allow women to indicate safeguarding needs via telemedicine. It also allows women to obtain abortions without travelling, which can be troublesome with a controlling partner who wants to prevent the abortion.
Yes, please see my answer to question 1
The only situation where a visit it is almost always beneficial is in cases when an interpreter is required.
Potentially, yes. A clinician can talk through everything with the patient, they can ensure they are physically well and that it is safe for them to take the medication. It also allows the clinicians to assess for any potential abusive situations, whilst giving the patient an opportunity to discuss such a situation in confidence with someone who can help. However, that clinician should, in my view, be a practice nurse at the local GP clinic. Any clinical concerns can be discussed immediately with a medical doctor.
Definitely,yes.
No - telemedical care allows people in abusive relationships a greater access to care as they do not have to access funds to travel or explain being absent from the home. All patients are asked if they are safe at home regardless of how they access the service. Abortion services are able to continue to provide face to face care where a safeguarding issue has been raised.
-
No. I think it could be offered for those who want it but does not need to be a requirement, unless there is a specific clinical need relating to the womans' particular health which puts her at higher than normal risk.
It shouldn't be REQUIRED though there may be benefits in be assessed.
I think good patient care can be given by a known care provider by non face to face means.
YES The woman needs to be assessed by a clinician in person. This is vital, for example, to spot an ectopic pregnancy, which could endanger the womans' life if she takes an abortion pill unsupervised. Also an in person visit would help prevent the woman being forced into having an abortion by an abusive partner.
Yes. Women need at least two visits to receive balanced counselling and to provide opportunity to consider carefully the outcomes.

Oes, os ydy'r person eisiau ymweld â gwasanaeth, ond os nad ydynt eisiau ymweld â gwasanaethau mae'n anfantais fawr.
The safety of women is better served by contact with medical professionals and they would have better care both physically and mentally resulting from this.
Most definitely. An ectopic pregnancy which is life threatening, may be missed. Domestic abuse is strongly associated with pregnancy, and abortion especially. Working on a postnatal ward, we always had to ask women and girls, when they were alone,if they were affected and needed help. It is estimated one in four are suffering domestic abuse.This opportunity for offering help was very valuable. As abortion is associated with abuse more strongly, it is even more important for medical assessment.
Yes there are clear benefits in being able to talk through the issue with someone in the caring / healthcare profession. Women can hopefully then understand the implications, the potential for physical and psychological harm, etc. It also gives opporunity to consider the truth of what abortion means, the killing of an unborn child in the womb, and the implications of this decision.
I consider it an absolute priority that women contemplating an abortion be required to attend a clinic for a personal ,one to one, consultation and medical check with suitably qualified personnel. There are some conditions which would only be discovered in a clinic. One of the most common and serious of these conditions is ectopic pregnancy. For women suffering from domestic abuse ,which as you know, is at record levels in Wales since the appearance of Covid-19, a visit to a clinic could be the only chance they might have of getting help or of having the abuse detected. The present arrangement is an abusers charter, enabling them to force abortion onto their wives/partners against their wills and /or consciences,
Yes, there are benefits to speaking to any health care professional. They can explain the process and give you reassurance. However, it is a privilege to be able to have the time and money to do so.
As someone who works in this area before retiring from the Health Service, I feel that a discussion and assessment by a clinician is essential. The patient is made aware of the procedure and the possible outcomes and remedies.
At least two. My wife worked in gynaecology 20 years ago and the ward were abused as birth control that long ago
Talking to someone in person, though it may be less ""efficient for service delivery"" or though it means ""value for money"" in the moment, is certainly not the caring service that we want to provide for women in our society. This sounds like it saves money in the short term but may be putting on women longer term consequences that are less obvious (mental health, etc).
There are clear benefits to requiring at least one in-clinic assessment, including overcoming many of the safety and safeguarding gaps with exist in remote services. They include: Verifying the identity of the woman; Accurately assessing the gestational age of the pregnancy; Assessing clinical eligibility. The risks to women carrying out a DIY abortion without visiting a clinic include: Not adhering to the precise time intervals between two stages of the abortion; Missing an ectopic pregnancy; Emotional distress; Domestic abuse.
women especially should be protected against any easing of the laws and the encouraging of immorality for younger people. Unless we do this the whole 'family' structure of society is in danger of collapse. Checkups where symptoms of covic should be available (and I believe are) must be available for all.
YES There is a clear and obvious risk in women being certified for an abortion without seeing a doctor in person. It significantly increases the risk of potential life-threatening conditions, such as ectopic pregnancy, being missed,
Without seeing a doctor in person the women is at risk from life threatening conditions. . To allow women to take strong abortion drugs unsupervised, strikes me as downright negligent. Clear advice and warnings from a doctor would reduce the risk. What about an abused women who was being coerced into a home abortion? It would reduce the risk if she had to go to a medical setting.
There are clear benefits to requiring at least one in-clinic assessment, including overcoming many of the safety and safeguarding gaps with exist in remote services. They include: Verifying the identity of the woman; Accurately assessing the gestational age of the pregnancy; Assessing clinical eligibility. The risks to women carrying out a DIY abortion without visiting a clinic include: Not adhering to the precise time intervals between two stages of the abortion; Missing an ectopic pregnancy; Emotional distress; Domestic abuse.
So risky to allow abortions without doctors okaying them.
There are clear benefits to requiring at least one in-clinic assessment, including overcoming many of the safety and safeguarding gaps with exist in remote services. They include: Verifying the identity of the woman; Accurately assessing the gestational age of the pregnancy; Assessing clinical eligibility.

The risks to women carrying out a DIY abortion without visiting a clinic include: Not adhering to the precise time intervals between two stages of the abortion; Missing an ectopic pregnancy; Emotional distress; Domestic abuse.
Mae risg amlwg o alluogi menywod i gael caniatad i erthylu heb weld meddyg yn gorfforol wyneb yn wyneb. Mae beighiogrwydd yn gyflwr cymhleth dros ben ac mae pob math o broblemau'n gallu codi, gan gynnwys er enghraifft feichiogrwydd ectoptig. Anghyfrifol hefyd yw datgysylltu gweinyddu tabledi erthylu oddi wrth gyd-destun meddygol. Gall menywod sy'n cael eu camdrin ddod o dan bwysau i erthylu gartref yn erbyn eu hewyllys. Mae mynnu bod menywod sy'n dymuno cael erthyliad yn mynychu lle meddygol megis clinig yn lleihau'r risg hon. Sut mae gwybod mewn gwirionedd fod y rhai sy'n cymryd y cyffuriau cryf hyn yn dilyn y cyfarwyddiadau?
There is a clear and obvious risk in women being certified for an abortion without seeing a doctor in person. It significantly increases the risk of potentially life-threatening conditions, such as ectopic pregnancy, being missed. Removing the administration of abortion pills from a medical setting could mean more abused women are coerced into a home abortion against their wishes. Ensuring women wanting an abortion go to a medical setting at least once minimises this risk.
Mae nifer o beryglon ynghylch peidio â chael asesiad gan glinigydd. Mae methu â gweld meddyg yn peryglu bywydau drwy golli problemau fel beichiogrwydd ectopig. Gall mwy o fenywod sydd yn cael eu cam-drin gael eu gorfodi i gael erthyliad. Dangosodd un astudiaeth y llynyedd nad yw nifer mawr yn dilyn y protocol a argymhellir wrth gymryd cyffuriau presgripsiwn a bu ymchwiliad y llynedd a ddatgelodd fod modd i unrhyw un a oedd yn gofyn am gyffuriau erthylu eu derbyn yn rhwydd. Byddai ymweliad â gwasanaeth asesu gan glinygydd yn lleihau'r perygl bod yr holl bethau hyn yn digwydd.
It has been suggested that a significant proportion of those taking prescription drugs do not follow the recommended protocols. This highlights the dangers of leaving women to take strong drugs like abortion pills unsupervised. Advice from a clinician helps mitigate the risk.
1. It has been suggested that people who take prescription drugs, study in BMC Health Services Research 11 (326) 2011, do not always follow the recommended protocols. Advice from a clinician would help to minimise this risk. 2. Life threatening conditions such as ectopic pregnancy could be missed. 3. Some abortion providers send out DIY abortion kits and have no real idea who is using them; this is dangerous.
Yes we do as Retired Dentist and my wife a retired SRN nurse we have seen the damage to women of impulse decision abortions pre 1967 .
I would think that, in some cases, a service user may have concerns they want to talk to somebody about but feel nervous about proactively seeking advice, which is the only advantage I can think of relating to the clinic appointments. I believe this advantage is outweighed by the advantages of the current model (as outlined in the consultation document)
Missing an ectopic pregnancy. If a woman is only having a consultation over the phone, an ectopic pregnancy can be missed. Ectopic pregnancy is life-threatening and women should not take abortion pills. In a report from the American Food and Drug Administration, 97 ectopic pregnancies were reported after women took Mifepristone. The initial consultation had missed the ectopic pregnancy.6 • Domestic abuse is strongly associated with abortion. Intimate partner violence (IPV) is a risk factor for abortion all over the world.7,8,9,10,11, Removing the provision of abortion pills from a medical setting increases the opportunity for abusive partners to force women into having abortions. • Missing the opportunity to detect domestic abuse. Studies on domestic abuse have suggested that there should be greater efforts to ask women if they are subject to domestic abuse when they present for an abortion.12 Remote abortion removes the opportunity for a healthcare professional to detect domestic abuse. Women are given no opportunity to discuss their pregnancy confidentially with a doctor.
No, there aren't. This can all be done electronically for people who wish to. From a safeguarding perspective it would put the pregnant person who could be in an abusive relationship at further risk of harm by having to try and make excuses to leave the house to attend appointments
Abortion pills sent to a home could easily result in a vulnerable women being coerced by others into proceeding with an abortion.
There are clear benefits to requiring at least one in-clinic assessment, including overcoming many of the safety and safeguarding gaps with exist in remote services. They include: Verifying the identity of the woman; Accurately assessing the gestational age of the pregnancy; Assessing clinical eligibility. The risks to women carrying out a DIY abortion without visiting a clinic include: Not adhering to the precise time intervals between two stages of the abortion; Missing an ectopic pregnancy; Emotional distress; Domestic abuse.
Removing the administration of abortion drugs from a medical setting could mean more abused women are at risk of being coerced into a home abortion against their wishes. Ensuring women wanting an abortion go to a medical setting at least gives them an opportunity for speaking to a clinician, or any individual for that matter, to obtain help and advice.

During an undercover investigation last year, abortion providers sent out 26 DIY abortion packs to 26 women callers. The callers were able to obtain pills using false NHS numbers and unverified gestational ages! So, these drugs could be going to anyone, with no checks at all on the process. This wouldn't happen with other powerful drugs, e.g. morphine, so why is this being considered as acceptable in this setting?
Yes, there are many benefits of in-person visits. Requiring a visit would reduce the likelihood of women being forced to have abortions against their wishes. It would increase the chance of support being provided in a timely fashion if complications result from abortion. It would also reduce the prevalence of the pills being taken in the wrong way.
There are clear benefits, as outlined above. (1) The identity of the woman can be verified. (2) The stage of the pregnancy, and any complications, can be established. (3) The client might be provided with a confidential space in which to speak up about any coercion they may be under. (4) The woman will not feel so alone, and, having been properly assessed, will not have to suffer any complications alone.
Questions are still asked regarding safety and safeguarding on telephone consultations. As a clinician you can usually gauge if someone else is present with the person. When medications are then collected it has to be alone therefore clinicians would ask those questions again then. Majority of patients would see a clinician even just to collect medications. All queries and concerns are addressed again.
There are enormous benefits to woman having at least one assessment by a clinician. Very vulnerable woman are more easily coerced into an abortion against their wishes without visit to a clinician. Other serious diagnoses such as an ectopic pregnancy could be missed without this visit. A visit to a clinician also means there is a legitimate known user of the pills, unlike during this pandemic where an undercover investigation revealed that abortion providers sent out abortion packs to all 26 mystery clients despite them using false NHS numbers and giving unverified gestational ages. The pills are being sent out without the safety checks that would be routine in a visit to a clinician which is extremely concerning.
Absolutely. East abortion is abhorrent and should never be decided upon in haste, without an in person assessment of the mother's well being and ongoing needs.
I think this service would benefit women in regards to safeguarding and safety. Some pregnancies are kept concealed for reasons personal to the woman. Therefore, the least amount of appointments the better for them, so not to raise suspicions from family members, friends and partners. Some women may not have the means to access appointments in person. COVID-19 has seen an increase in women at home with their abuser, once again, more reason for suspicion should a women require services for termination. Atleast with the current service, women with safety and safeguarding concerns have the option to complete the termination at home, but also the option to attend the hospital.
One visit to a service for assessment by a clinician should be regarded as an essential minimum for a procedure with such far-reaching implications. See further my response to Q3 above.
I can think of two safeguarding issues. Firstly, women and girls in abusive relationships can be coerced into having a medical abortion, and the lack of guaranteed privacy during a phone consultation means that this type of situation is unlikely to be freely discussed. Secondly, women and girls with a poor education may struggle to follow the proper procedure for taking the pills and not be well-prepared for any possible side-effects.
Gestational age is much easier to ascertain. Ectopic pregnancy is much more likely to be diagnosed. Domestic abuse is more detectable.
Yes, definitely. That is far more preferable than merely a telephone conversation. As I understand it, two doctors need to be involved. A telephone conversation is wholly inadequate in the light of the risks involved.
Staff would be able to assess the gestation of the pregnancy more accurately and should eliminate those who are beyond 12 weeks gestation from a simple abdominal examination. Sensitive questioning should reduce the chances of women being forced to have EMAH by coercive partners.
The benefit of face to face consultation ensures that the woman requesting abortion is actually within the legal time frame. The clinician is better able to assess safeguarding issues and hopefully has time to fully discuss the consequences of the decision withe the woman.
Of course, something as serious as terminating a life must be considered carefully and all pros and cons understood by the woman herself.
Women in difficult and unsafe circumstances now more likely to seek regulated abortion care now that they will not need to travel to clinic to access abortion services. Abortion services continue to provide in person care where telephone consultations raise safeguarding concerns. Abortion providers report that providing care remotely led to increases in the number of women disclosing problems at home. In the first 3 months of the Pills by Post service 10% of clients underwent an enhanced safeguarding risk assessment, a 12% increase compared to March 2020. Clinicians report that telemedicine has made women more willing to disclose concerns about safety as opposed to care provided in a clinical environment.
Yes - going to be assessed is important to give the woman a chance to talk to the clinician one to one, they also have the opportunity to ask any questions they want to understand better that they may not feel they can ask with others present (which can never be guaranteed over the phone)
yes great benefits to women in general to have at very least one visit to specialists
Yes, there are great benefits. An in-clinic check will be able to help verify the identity of the patient and check on the clinical aspects. Without these visits, patients are at risk of not having clinical problems found, of being coerced, and not taking the pills with the right time interval.
Yes for the reasons stated above.

In the interest of the safety of women at least one in-clinic assessment should happen, also overcoming the gaps in that exist in remote services. They include:- Verifying the identity of the women. Assessing gestational age Missing a ectopic pregnancy Domestic abuse
I feel that it is dangerous for drugs to be sent to someone as there is no telling who might take them and whether they will follow the instructions. There are no proper checks as in an undercover investigation last year 26 woman obtained abortion kits using false NHS numbers and unverified gestational ages. You could get very young girls using these as a means to get rid of an unwanted child but they themselves may still be a child and need proper support
Clearly there are benefits to a woman having at least one visit to a clinician - her identity can be checked, the length of the pregnancy can be checked and suitability of use of the drugs in this case can be checked. A qualified clinician could also see problems, eg ectopic pregnancy, which the mother may not be aware of. Also, without an assessment visit, it may be possible that the mother is being coerced into the abortion against her will.
Yes (but that of course doesn't make the abortion right). A particular danger is the risk of an ectopic pregnancy – which also, incidentally, appears to be linked to Mifepristone – but this can be detected by a clinician. So also can any signs of domestic abuse leading to forced abortion.
Yes, I think having an in-person visit is safest to verify the woman's identity and pregnancy, to accurately check the gestation and whether it's an ectopic pregnancy and to allow the woman a private place to express emotional distress or domestic abuse to staff on a 1:1 basis, which they may not feel able to do at home, depending on their circumstances.
See my answers to Question 1 and Question 3. Yes, there is an essential benefit to women's safety in requiring them to make at least one visit to be assessed by a clinician. Women's safety is the most important factor, and this has been compromised by the approval of abortion pills taken at home. The home is not a safe place for a significant minority of women. Girls and women who are being abused can be forced to take abortion pills against their wishes in the privacy of the home. Child sexual abuse victims can be forced to take an abortion pill if they become pregnant without any doctor being aware of the pregnancy or the pill. It is hard for people who have never been the victims of abuse to understand how helpless women can be in their own homes. As a former abuse victim myself, I am aware that had this option been available twenty years ago, my ex husband might very well have forced me to take these pills at home to have an abortion. Women must have the right to a consultation alone with a doctor, and to make the decision to take the pill in a situation where an abuser is not present. This right is taken away when pills are supplied to women at home.
A medical visit would naturally help to safeguard mothers.
There are clear benefits to requiring at least one in-clinic assessment, including overcoming many of the safety and safeguarding gaps with exist in remote services. They include: Verifying the identity of the woman; Accurately assessing the gestational age of the pregnancy; Assessing clinical eligibility. The risks to women carrying out a DIY abortion without visiting a clinic include: Not adhering to the precise time intervals between two stages of the abortion; Missing an ectopic pregnancy; Emotional distress; Domestic abuse.
I believe that there are obvious benefits to requiring at least one in clinic assessment. These benefits include, but are not limited to: Providing an opportunity for the woman to discuss any coercion or fears she may have. Ensuring that the woman is who she claims to be. Ensuring that the woman is clinically eligible being able to accurately ascertain the age of the pregnancy.
I feel that all abortions should be supervised by a medically qualified person rather than having home diy abortions. There are so many risk areas that make home abortions unsafe. For ex without medical supervision the drugs could be taken incorrectly, physical issues such as ectopic pregnancy would be missed. I understand that during an undercover operation last year 26 people were able to obtain diy abortion packs giving false names and NI numbers so the abortion providers have no idea who is using their drugs.
I think it is essential for a woman's safety and safeguarding to have a face-to-face assessment with a clinician. To be able to explore all the facets of such a far-reaching and final decision, eg having a scan can change a woman's mind as I am aware. This is a matter of life and death, and can have lifelong lasting mental health implications, which needs thorough consideration and assessment, which it is hard to believe can be adequately done without proper appointments.
Yes, to establish that the woman really wants an abortion, that the pregnancy is at a sufficiently early stage, that she does not have health issues such as ectopic pregnancy, to make sure she realises that abortion means killing a child with his or her own identity rather than a random clump of cells.

No. Abortion providers have robust processes in place to flag safeguarding concerns and investigate them; independent providers report the same rate of detection of safeguarding issues before and after the introduction of telemedicine, and it has been suggested that better privacy at home enables women and pregnant people to talk more freely.
There are NO benefits in mandatory clinic visits - clinical, safeguarding or otherwise. Within the telemedicine model, there is already capacity to invite patients in to clinic if there are concerns about gestation/ectopic/ safeguarding and forcing all patients to attend would have no further benefit.
Quite clearly there are risks involved in not being assessed by a clinician. The pregnancy may well be past the prescribed limit or the woman may be subject to other pressures to terminate the pregnancy.
A Safeguarding assessment is a routine part of every telephone consultation for abortion. In addition to this women are provided with a 'safe word' that can be used when a health professional calls them Our staff are vigilant and ask women not to use speaker phones and we can initiate a video consultation if we have any fear of coercion. All under 18th have a more robust safeguarding assessment form our Youth worker and there is an opportunity for any women to speak to a counsellor if she would like to (either in person or via teleconsultation)
Yes I do. I feel that a visit to a service to be assessed by a clinician allows for some time for reflection, it allows the clinician an opportunity to ensure that the request for the abortion is being taken in the full knowledge of what is involved. It also ,hopefully, gives an opportunity to assess for coercion on the part of a third party.
Yes, babies have rights too - just because a foetus isn't immediately recognisable as a human being changes nothing.
I believe that women that seek to have an abortion need to be seen by a clinician and they need to hear about all options open to them. And that includes carrying the baby to completion and giving it up for adoption or for the women to keep the baby. They need to be sure that an abortion is what they want.
Yes. Requiring women to make at least one visit to a service to be assessed by a clinician is very beneficial. For example, verifying the identity of the woman and accurately assessing the gestational age of the pregnancy. Risks to women having a DIY abortion without visiting a clinic include not adhering to the precise time intervals between two stages of the abortion, emotional distress and domestic abuse. The risks would obviously be mitigated if the woman has to be assessed by a clinician.
No benefits, many disadvantages
For those women who are in abusive relationships or have been trafficked to the UK a visit to an abortion clinic could give the first opportunity to get help. This is denied them through the pills by post scheme. And undercover investigation in June/July 2020 found a lack of checks on women's identity or gestational age of foetus. https://christianconcern.com/resource/abortion-at-home-a-mystery-client-investigation/
For women who want to have a face to face visit that option should available but the evidence from the study done when telemedicine started after lockdown it seems that the removal of the need t travel was beneficial for women with controlling partners so they felt safer. As it was easier to arrange more women may have reenable to achieve their aims terminating a regnancy. In my expericne abusive men are more likely to force a women to continue an unplanned pregnancy she does not want then put pressure on her to abort a wanted pregnancy
Yes
No. Providers are becoming more adept at on line consulting for women in vulnerable positions. In face, to insist on attending could be more of a risk
Yes. The safeguarding benefits are: - confirmation of identity of women; privacy and confidentiality provided; identification of domestic abuse. The safety benefits are: - accurate assessment of gestation; assessment of mental state; opportunity to give full information, verbally and written, of risks of abortion at any gestation and under any circumstance. It is still imperative that medical supervision is provided for the abortion procedure as well as assessment.
Yes, to verify gestational age, ID, problems such as an ectopic pregnancy, also possible domestic abuse etc.
Yes. I think by ensuring at least one face to face visit is undertaken is important. This allows women and girls to have the opportunity to speak to a professional face to face and alone if the choose thus reducing safeguarding risks and the risk of coercion. In a hospital setting it can be ensured that private and confidentiality in always maintained. . It will also ensure that the gestation is correct and therefore can greatly reduce the chance of medication been given after the 9 week, 6 day gestation limit. It would reduce the chance of the medication being used by another person if the first was given under the supervision of a clinician.
This arrangement significantly increases the risk of potentially life-threatening conditions, such as ectopic pregnancy, being missed as the woman will not have been checked over by their doctor.
For some women, it may be more beneficial for them to attend a clinic environment, in particular if there are safeguarding issues such as domestic abuse, however, this should be part of the offer rather than a necessity. Some women may not feel comfortable with a home arrangement and wish to see a clinical face to face, and again, this should be offered as an option.
There are clear benefits to requiring at least one in-clinic assessment, including overcoming many of the safety and safeguarding gaps with exist in remote services. They include: Verifying the identity of the woman; Accurately assessing the gestational age of the pregnancy;

Assessing clinical eligibility. The risks to women carrying out a DIY abortion without visiting a clinic include: Not adhering to the precise time intervals between two stages of the abortion; Missing an ectopic pregnancy; Emotional distress; Domestic abuse.
Having an examination would determine what is the correct medication for a patient. It would ensure that the prescription is being given to the person who requires it and that the prescription is taken has required.
There are clear 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. Many women who share their stories with Her Voice report feeling rushed through their decision, and wish they were given more time. Ellie, when reflecting on her own medical termination, wrote: "I wish the clinics knew we are not just another statistic. If I had the chance to actually sit down and talk to someone beforehand, I know that I wouldn't have gone through with the abortion. We are rushed through the process and before we know it, it's too late - or at least they make us feel that way. They don't take into account that our hormones are already going crazy, along with the stress of what else is going on in our life to put us in this situation to begin with. They should take the time out to sit with people, instead of rushing them." Early medical terminations at home deny women these further opportunities to speak with someone about their situation. In these consultations they can share their concerns about their situation and even have the opportunity to disclose abuse. To remove these opportunities for a woman is to disregard the many factors and even the ambivalence that is affecting her decision.
Yes,
There are clear benefits to requiring at least one clinic assessment, including overcoming many of the safety and safeguarding gaps which exist in remote service areas including: verifying the woman's ID and assessing clinical eligibility. Risks to women carrying out DIY abortions without a clinic visit include: not adhering to precise time intervals between the 2 stages of an abortion, missing ectopic pregnancies, emotional distress and domestic abuse.
There is huge risk in abortions being carried out without medical supervision. Abused women could be coerced into a home abortion against their wishes. Going into a medical setting lessens the risk. It is likely that people taking prescription drugs do not always follow the instructions. It is dangerous for women to be taking these strong drugs unsupervised. Medical involvement decreases the risk.
There are risks to as many do not follow women taking strong drugs unsupervised as many do not follow the correct procedure.
No. There is a clear risk to women having an abortion without seeing a doctor, especially if they have other underlying health conditions. Advice from a medical professional would mitigate risk. Women in abusive relationships could now be more easily coerced into having an abortion, at home.
Yes, there are benefits in relation to safeguarding and women's safety in requiring them to make at least one 'in person' visit to a service to be assessed by a clinician. These include: Safeguarding 1. Clinical examination allows better chance of detecting domestic abuse. 2. 'In-person' consultation is much less open to coercion of the client into procuring abortion. 3. Reduced chance of medication being supplied to, or at the behest of a person other than the intended recipient (eg to an individual in a coercive or abusive relationship with the intended pregnant recipient). Safety 1. Accurate assessment of the gestational age of the pregnancy, which is not possible without clinical examination. 2. Assessment of medical suitability of the client, if out-of-clinic termination is being considered. 3.Assessment of the mental state of the client, and provision of appropriate counselling and support as needed.
As above regarding coercion. As above regarding the increased risk this poses in conditions like ectopic pregnant not being diagnosed. There is also no guarantee or who or where these are being used.
Definitely, women's mental health can be fragile when pregnant and this is literally a life and death decision they're making, many women live with a guilty conscience for the rest of their lives. They need to have time to talk through what they're doing and realise what will happen to avoid unnecessary mental health issues
What if the woman is suffering from an ectopic pregnancy or has pre-eclampsia? A clinician could assess this - whereas just being sent the pills and getting on with it could ensure the mother's death.
There is a clear and obvious risk in women being certified for an abortion without seeing a doctor in person. Does the women understand exactly what is going to happen, what are the options available to her outside of an abortion, what are all the risk involved including potentially life-threatening conditions, such as ectopic pregnancy, being missed. Going for treatment of any kind that may involve serious risks, surely requires more than a cursory visit to a clinician. During an undercover investigation last year, abortion providers sent out 26 DIY abortion packs to all 26 women mystery clients. The callers were able to obtain pills using false NHS numbers and unverified gestational ages. The reality is that abortion providers are sending out DIY abortion kits and they have no idea who is using them.

Abortions carried out with medical supervision are as equally wrong as abortions carried out with no medical supervision. However, not attending a clinic presents a number of additional risks to women, which we would like to highlight.

• Not adhering to the precise time intervals between the two stages of the abortion. The timing between taking Mifepristone (the first pill) and taking Misoprostol (the second dose) is critically important. Taking the second dose incorrectly increases complications for the woman and she may require surgery. There is nothing to stop a woman taking the second stage of drugs outside the recommended time frame if she is not under medical supervision. Research has shown that, unsurprisingly, women prefer a short time frame between the pills (https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2014/03/medical-management-of-first-trimester-abortion), and so may be inclined to take the second dose less than 24 hours after the first. But this leads to a significant increase in complications with one study finding that nearly one out of every three to four women who took buccal Misoprostol shortly after the Mifepristone failed to abort (https://www.ncbi.nlm.nih.gov/pubmed/17707719). (While SPUC would not consider the continued life of a baby to be a “failure”, a woman still intending to end a pregnancy would then undergo a surgical abortion in a medical setting – negating any “benefit” of a home abortion.)
• Missing an ectopic pregnancy. If a woman is only having a consultation over the phone, an ectopic pregnancy can be missed. Ectopic pregnancy is life-threatening and women should not take abortion pills. In a report from the American Food and Drug Administration, 97 ectopic pregnancies were reported after women took Mifepristone. The initial consultation had missed the ectopic pregnancy (https://www.fda.gov/media/112118/download)
• Emotional distress. Many studies show that women experience emotional distress after an abortion and other studies show mental health problems for women after abortion. Home abortions may lead to more adverse psychological consequences, in part because a woman may be alone when she aborts and may also see the foetus who is expelled.

Other risks which must be considered:

Regulating DIY abortions. DIY abortion is impossible to regulate effectively. In England, police have investigated the deaths of a newborn baby (https://www.thesun.co.uk/news/12273020/newborn-death-pills-by-post) and a baby at 28 weeks gestation (https://www.thesun.co.uk/news/11690506/police-probe-death-of-unborn-baby-after-woman-has-illegal-abortion-by-post-at-28-weeksfour-weekspast-limit) after their mothers took abortion pills sent in the post well past the legal limit. A mystery client exercise also revealed that abortion providers are sending women abortion pills without proper checks.
• Domestic abuse is strongly associated with abortion. Intimate partner violence (IPV) is a risk factor for abortion all over the world (study references available on request). Removing the provision of abortion pills from a medical setting increases the opportunity for abusive partners to force women into having abortions.
• Missing the opportunity to detect domestic abuse. Studies on domestic abuse have suggested that there should be greater efforts to ask women if they are subject to domestic abuse when they present for an abortion (https://obgyn.onlinelibrary.wiley.com/doi/pdf/10.1576/toag.11.3.163.27500) Remote abortion removes the opportunity for a healthcare professional to detect domestic abuse. Women are given no opportunity to discuss their pregnancy confidentially with a doctor.

The benefits are: clinical eligibility can be properly assessed, gestational age can be accurately verified, as well as the
identity of the woman.

Yes. Most importantly it reduces risk to women's safety in that it protects them by having an abortion certified by them seeing a doctor in person. It significantly increases the risk of potentially life-threatening conditions, such as ectopic pregnancy, being missed.
I also think it benefits women's safety in that it protects them from the risk of them being coerced into a home abortion against their wishes. Ensuring women wanting an abortion go to a medical setting (at least once) minimises this risk.

There is a obvious risk in women being certified for a Abortion without seeing a doctor, Women could be forced into an Abortion against there wishes, having at least one medical appointment would go some way of minimising the risk. Taking a strong drug like an abortion pill should be supervised to minimise the risk. Abortion provides are sending out powerful drugs with out knowing who is taken them.

Facilitating such a consequential procedure as an abortion without regular medical advice and assessment would be irresponsible to the point of professional neglect. The health risks to the woman, both physical and emotional, plus the inevitability of sometime abuse and coercion, make the practice of strict control and supervision absolutely essential.

I think it is absolutely essential to visit a qualified clinician , one who unbiased when it comes to a life-threatening situation. A pregnant woman or young girl are very vulnerable at such times and need very tender and sensitive counselling.

Home use of both abortion medications does not necessarily mean that consultation will be remote. This change in the law would allow completely remote abortion care including consultation by phone or videolink. However, in some instances it would also mean that women who prefer to be seen in a clinic. Or, if service providers consider her to vulnerable then they may request that she attend a clinic appointment. Following a clinic appointment, both pills could still be administered in a place where the woman feels more comfortable.

As noted above, home-use of both pills is safe. Vulnerable women, notably those living in abusive and violent relationships may struggle to get to a clinic. So, home-use is a far safer option for them, for their overall health as well as abortion care (Aiken and others, Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain, 2018, https://pubmed.ncbi.nlm.nih.gov/28941978/).

Yes Coercion is detected and gestation of the unborn child can be more accurately assessed
Yes, there are clear benefits in requiring at least one in-person consultation in relation to safeguarding and women's safety. 1. An in-person consultation enables the woman's identity to be verified, avoiding the possibility of impersonation. 2. A consultation enables the gestational age to be clinically assessed to ensure that the woman is eligible for the pills. 3. An in-person consultation ensures that the woman is not being coerced by an abusive partner who may be listening in to a telephone consultation. 4. An in-person consultation enables the provider to clinically check that it is safe for the woman to take the pills. 5. An in-person consultation will ensure that the first pill will not be taken by another woman or forced on another woman.
Benefits of seeing women face to face - assess their mental state - and greater support to those who are in two minds - possibility to pick up coercion from others in an individual consultation - possibility to protect from high gestations dangerously aborting at home - possibility to check for ectopic pregnancies and help mitiage the dangers associated with ectopic and unsupervised abortion including bleeding.
I don't see the need.
• Every woman is asked by abortion providers whether they are safe at home. This is a routine part of abortion care, no matter how or where care is provided. For instance, one NHS service in Wales gives women a safe word in their first interaction so they can raise concerns in the event they are not able to find somewhere private to speak. • Some women seeking access to services are in relationships or home environments where their behaviour and travel are monitored – meaning travelling to an abortion clinic is difficult or dangerous. Telemedicine enables these women to access abortion care without risking their personal safety. • Women in difficult circumstances are now more likely to seek regulated care and support in the knowledge that they will not be forced to travel to a clinic to access that help – the online pill provider Women on Web, which frequently received requests from women in coercive or controlling relationships, reports these women are now able to access legal care. • Abortion services continue to provide in-person care where telephone consultations raise safeguarding concerns such as safety or privacy at home, ability to consent, or wider safety concerns surrounding existing children or statutory concerns such as Female Genital Mutilation • Abortion providers report that providing care remotely led to increases in the number of women disclosing problems at home. BPAS reported that in the first three months of their Pills by Post service, 10% of clients underwent an enhanced safeguarding risk assessment – a 12% increase compared to March 2020. • Clinicians providing abortion services report that telemedicine has made women more willing to disclose concerns about safety when in the privacy and familiarity of their own surroundings, as opposed to a clinical environment
Yes. A face-to-face visit with a clinician would give the professional the opportunity to asses the physical and mental wellbeing of the woman, and gain some feeling if coercion was involved. It would give the woman an opportunity to carefully consider the consequences of her decision. A clinician would be able to ascertain how far the pregnancy has progressed.
Removal of the administration of abortion pills from a medical setting may lead to women being coerced into a home abortion against their will. This risk would be minimised if women seeking an abortion had to attend at least one medical setting.
No, There is no clinical benefit to having a statutory blanket requirement for women to make at least one visit to a service:
No, I don't think that this is necessary. It would counter all the benefits listed above.
I do. But can this not be done over zoom anyway?
Yes, women requiring an abortion should have face-to-face access to a clinician. A phone consultation can easily miss an ectopic pregnancy and taking abortion pills could then put the women's life at risk. Violent sexual partners often force women to have abortions against their will. This and other forms of domestic abuse are more likely to be picked up if the women is able to have a confidential, private face-to-face consultation with a clinician.
Yes definitely. By providing a safe space to discuss her situation it would give the clinician the opportunity to pick up whether this is the woman's decision or if she is being put under pressure. Also a physical visit could confirm pregnancy and also gestation or if ectopic pregnancy.
Women in abusive/ controlling relationships can access legal care more easily.
I don't know / Yes. Providers tell the woman to watch out for signs of complications and tell her what signs to watch for, eg heavy bleeding, or incomplete abortion, and tell them if they get any signs to go straight to A&E ... don't phone us, just go. The provider gives the warning signs but it is the woman who has to assess whether she is bleeding too much, or whether it hasn't properly worked. The provider has discharged their client at the point that they send out the pills. None of the mystery clients received follow-up calls from the provider. FOI requests made to NHS trusts and ambulance services. Data coming back supports the view that ambulances are responding to women who are self-reporting complications. The number of such women is not declining - it is as high as ever.

Abortion providers are suggesting DIY abortions are safer ... but actually they don't know, because they fill in the form before the pills are taken. So the complications are showing up at A&E, NOT back with the provider.
It is very important that the number of weeks of the pregnancy is accounted for before administering abortion tablets I believe it is important that the woman has an opportunity to have a scan to see the baby before she makes her decision To abort. If anything goes wrong with the abortion process I believe it's very important that the woman has immediate access to medical services.
For some women, such anyone who has been subject to rape or is in an abusive relationship,,the opportunity to discuss this coudl be helpful, but unless there are health care issues which would require medical advice and/or support , I feel that the vast majority of women are quite capable of self medication to induce abortion within the parameters. Medical support should still be available.
With Home abortions women in abusive relationships can be forced into having an abortion against their will.
Yes, but the benefit of home use is also significant.
Every woman is asked by abortion providers whether they are safe at home. This is a routine part of abortion care, no matter how or where care is provided. For instance, one NHS service in Wales gives women a safe word in their first interaction so they can raise concerns in the event they are not able to find somewhere private to speak. • Some women seeking access to services are in relationships or home environments where their behaviour and travel are monitored – meaning travelling to an abortion clinic is difficult or dangerous. Telemedicine enables these women to access abortion care without risking their personal safety. • Women in difficult circumstances are now more likely to seek regulated care and support in the knowledge that they will not be forced to travel to a clinic to access that help – the online pill provider Women on Web, which frequently received requests from women in coercive or controlling relationships, reports these women are now able to access legal care. • Abortion services continue to provide in-person care where telephone consultations raise safeguarding concerns such as safety or privacy at home, ability to consent, or wider safety concerns surrounding existing children or statutory concerns such as Female Genital Mutilation • Abortion providers report that providing care remotely led to increases in the number of women disclosing problems at home. BPAS reported that in the first three months of their Pills by Post service, 10% of clients underwent an enhanced safeguarding risk assessment – a 12% increase compared to March 2020. • Clinicians providing abortion services report that telemedicine has made women more willing to disclose concerns about safety when in the privacy and familiarity of their own surroundings, as opposed to a clinical environmen
Yes. Women need guidance, understanding and counselling as regards these matters.
No, none at all, unless the woman concerned prefers it. Most have said they would not. Safeguarding and health concerns can be addressed just as well by telemedicine.
Research taht has alreday come out and is still emerging about telemedicine has shown that it is as safe, as good, and in many ways better than standard care. There forcing all women as a blanket rule to attend the service in person cannot now be justified. Of course, the option for face-to-face consultation should always be there and will always have its place, but this should not be enforced on all women with no justification.
Yes To ensure they have appropriate support, advice and guidance
See answer to Question 3. Also missing at least one visit to clinician may cause: Emotional distress caused by trauma of abortion. Domestic abuse when women are coerced into abortion.
I support the views of the health professionals in this matter. I am not a health professional myself but I respect the experts in their field.
Yes. There are benefits such as screening for irregular pregnancies which, if subjected to abortion, can endanger the life of the mother. Ectopic pregnancy is an example of this. Such cases cannot be identified by telephone communication alone. The remote nature of a telephone consultation removes the ability to identify women who are being physically abused by their partners and allows the partner to force a woman to take abortion pills against her will. A visit could enable a clinician to detect any coercion to take abortion pills.
Yes, I do- especially for the women who have suffered domestic and sexual abuse and were coerced into abortion. This might not be apparent via a telephone or video consultation, therefore the opportunity to help these women will be missed, leading to further cycle of sexual abuse and psychological and emotional consequences for the women. Another major consideration id the fact that lack of face-to-face consultations will miss ectopic pregnancies, which can be life-threatening.

All women are asked whether they feel safe at home and there is a clear referral pathway for safeguarding within our abortion care pathway. By reducing barriers and improving accessibility there has been a steady increase in women disclosing concerns and therefore being referred for safeguarding and risk assessment. The flexibility now provided by telemedicine allows women to call us rather than being forced to come to a clinic or hospital when transport may be an issue. We also have access to video calls if we have concerns related to patient safety, some patients prefer this form of consultation.
During a telephone consultation ectopic pregnancies cannot be detected; so physical examination by a medical doctor should detect this and prevent prescribing drugs which would cause more risk to the woman. The signs of domestic abuse detected during a consultation with a doctor/healthcare professional gives opportunity for social services to intervene and prevent the woman being forced to have an abortion against her will by a violent husband/intimate partner.
There have not shown to be any increased risks around safeguarding or safety by using telemedicine. Women surveyed have said that they feel able to share freely with practitioners both ways.
There are clear benefits to requiring at least one in-clinic assessment, including overcoming many of the safety and safeguarding gaps with exist in remote services. They include: Verifying the identity of the woman; Accurately assessing the gestational age of the pregnancy; Assessing clinical eligibility. The risks to women carrying out a DIY abortion without visiting a clinic include: Not adhering to the precise time intervals between two stages of the abortion; Missing an ectopic pregnancy; Emotional distress; Domestic abuse.
If administration of abortion treatment is away from a medical situation, there is a a greater risk of an abused woman being coerced into a home abortion against their wishes. Undercover investigations have revealed that false NHS numbers an unverified gestational age still can ensure supply of these abortion kits.
Women are often in shock when they become pregnant and may well see abortion as a quick and easy solution before they have had proper time to reflect. Therefore there are real advantages in women's safety that they are required to talk through their decision with a third party and be able to explore how they see it and what it means to them. They are choosing to end a life and it is a decision that should not be taken lightly. There are also advantages that they should be at a place to receive medical help in the event of excessive heamorraging.
Yes. They may realise these huge seriousness of deliberately ending the life of the unborn child in their womb.
Yes - clearly there are benefits by being assessed by a clinician . Serious medical conditions could be missed , for example ectopic pregnancy and confirming the pregnancy is under 10 weeks gestation. Also taking the medication unsupervised might mean it is not taken correctly . Pills sent out could be to sent out without having any idea who was using them .
I believe there are benefits in terms of both safeguarding and safety, primarily with respect to ensuring confidentiality and genuine freedom to decide, checking that gestation is really under 10 weeks and monitoring for any immediate complications.
No. There is no clinical benefit to having a statutory blanket requirement for women to make at least one visit to a service: the evidence presented in this consultation response shows that a remote service is as safe and as effective as an in-person service. Reinstating a legal requirement for women to make at least one visit would therefore represent an unwarranted and politically-motivated interference that would disproportionately affect women from disadvantaged groups. ● Similarly, there is no benefit in relation to safeguarding to having a statutory blanket requirement for women to make at least one visit to a service: abortion care providers are bound by law and professional guidance to act on any safeguarding concerns, and so everyone who access abortion services is asked if they feel safe at home, whether that is via telemedicine or during a clinic visit. ● Abortion providers have reported that better privacy at home enables women and pregnant people to talk more freely, and they report the same rate of detection of safeguarding issues before and after the introduction of telemedicine. ● Face-to-face appointments are still available when clinically indicated, for women who feel they need them and for those about whom providers have safeguarding concerns; making recent regulatory changes permanent would not change this.
There are barriers to accessing in-clinic services - this highlights health inequalities like socioeconomic factors - needing time off work, childcare etc. There is no clinical need for in-person appointments for EVERYONE. In-clinic appointments are still available for those who need them.
I strongly believe there are huge benefits to being seen by a clinician. Women need physical and mental support throughout the decision process and any suggested treatment. Clinicians are trained to mitigate against complications.
This face to face clinic option should continue to be a permanent option for women who wish to access it or for women where medically/socially it would be safer for them to access it. Making face to face a requirement is what causes the disadvantages, by removing the choice, flexibility, better accessibility and safe option of telemedical access to mifepristone and misoprostol at home.

Abortion providers have reported that better privacy at home enables women and pregnant people to talk more freely, and they report the same rate of detection of safeguarding issues before and after the introduction of telemedicine.
Mae telefeddygyniaeth wedi gwneud e'n haws i ferched sy'n dioddef camdrin domestig i gael mynediad at wasanaethau erthyliad, gan nad oes rhaid iddynt deithio neu fynd at wasanaeth - gan fyddai rhai partneriaid yn atal merched rhag wneud hyn. Mae data o'r gwasanaethau wedi dangos bod mwy o ferched wedi rhoi gwybod am achosion o drais yn y cartref wrth ddefnyddio telefeddygyniaeth.
There are clear and important benefits for women's safety in requiring them to make at least one visit to be assessed by a clinician. The woman can be examined to check whether it is safe and advisable for her to have an abortion. She can discuss any worries and her needs for follow-up and after-care can be assessed. If she is in an abusive situation where she is being coerced, it is an opportunity for this to be recognised and addressed. It is also a safeguard against the pills being administered beyond the 10 week limit.
Like there might be benefits to requiring a meatspace appointment but there are also risks? For a start what if you can't afford the bus or train fare to the clinic? If your weekly benefit is £58 odd for example and you'd have to pay a £12 return fare (for example, from the valleys to Newport on the train), that's about 20% of your weekly income gone, that's a massive burden. What if being seen at a clinic known to provide abortion services (for example by a family or community member) is a risk to an individual's safety? Completely online ToP services mitigate risks such as these
Yes , this should happen for the girl or women's safety.
Yes. There are many benefits. The exact stage of gestation and whether or not the pregnancy is actually viable can be determined by physical examination and ultrasound examination. This cannot be done by telephone consultations alone. Meeting the pregnant woman face to face and having a detailed discussion of her options and what abortion involves will help the provider to recognise if the woman truly wants to undergo this procedure and that she is not being coerced by others to do something against her will. It also ensures that the woman receiving the abortion-inducing medication is actually the woman for whom these drugs are intended and that they are not being obtained for provision to another person, possibly a minor or a victim of abuse. The current law, including the temporary measure, allows for Mifepristone and Misoprostol to be provided by post following a telephone conversation with a recognised abortion provider but only if the pregnancy has not advanced beyond 10 weeks. Requiring at least one visit to a service, with review by a qualified clinician, helps to ensure that these medications will not be provided at later stages of pregnancy without adequate supervision. To administer them at later stages, without adequate supervision, carries a potential serious risk to the woman who receives them.
It is most important for a woman considering an abortion to visit a medical professional in person to be assessed thoroughly, it is necessary to know exactly the gestational age of the baby she is carrying, to make sure the woman is not being coerced into the abortion, to ensure her physical and mental health are ok. She can then be provided with the best support she needs. Any thorough and effective support for women in this difficult life changing situation will have huge benefits to her physical and mental wellbeing and therefore that of the people around her too, not least other children in her care. She may even be able to find the strength to give the child she is carrying a chance to live their life, this will have untold benefits to her and her child.
• As previously mentioned, early medical terminations at home can put vulnerable pregnant women at greater risk of abuse and reproductive coercion. Pregnancy can be a trigger for domestic abuse, and existing abuse may get worse during pregnancy or after giving birth. Abusers who know that women can get abortion pills through the post will be able to cover up their abuse more easily. Studies on domestic abuse have suggested that there should be greater efforts to ask women if they are subject to domestic abuse when they present for an abortion. Remote abortion removes the opportunity for a healthcare professional to detect domestic abuse. Women are given no opportunity to discuss their pregnancy confidentially with a doctor. Additionally, it is made easier for a partner or family member to coerce a woman to have an abortion she otherwise does not want. • Another issue from terminations at home is the possibility of missing an ectopic pregnancy - If a woman is only having a consultation over the phone, an ectopic pregnancy can be missed. Ectopic pregnancy is life-threatening, and women should not take abortion pills if they are experiencing an ectopic pregnancy.
There are definite advantages - confirmation of date, ruling out ectopic pregnancy and other potential complications, ensuring coercion and other abusive relationships are not involved and offering support to those who need it. Ensuring the woman understands the correct procedure for administering the drugs and is aware of what should flag that assistance is required and where this can be accessed. Referrals for mental health or other emotional support if necessary.
It is undeniable that the quality of client-centred counselling and responding specifically to the client presenting to you, is so much better when conducted face-to-face. It is very difficult for even the most experienced counsellor to fully satisfy and discharge their professional obligations to ensure the safety and wellbeing of their client when consultation is by phone only. Those professional counselling organisations which have decided to continue providing services remotely during the pandemic, do so only by video-call, never by phone alone, and always with in-person consultations readily available and accessible when required. Our mystery client investigation reveals the inadequate quality of safeguarding afforded to women making telephone

calls to the abortion providers. None were asked to attend the clinic; none were asked to use video-call instead of the phone. Those who requested counselling were unable to get a face-to-face appointment and the waiting times for telephone counselling would have meant that they would have exceeded the 9 weeks 6 days limitation on EMA at home in any case. A number of our mystery clients were making the calls whilst seated beside their abusive, coercive partner and this was never detected as a safeguarding risk by the abortion provider.

http://percuity.blog/mystery-client-survey/

As outlined above, the EMA at home model does not present additional risks to women's safety. There is also some evidence which indicates that the EMA at home model (which does not require a visit to a service) does not disadvantage women, but in fact, may increase participation in safeguarding exercises and access to safeguarding.

Moving to telephone and video consultation simply changes the place where safeguarding occurs. Robust safeguarding processes have been developed to ensure that all women with a safeguarding risk are identified, regardless of age. Staff providing telephone consultations are trained to identify risk factors which make women socially vulnerable, this includes age under 18 years, child protection needs, domestic violence and abuse, mental health concerns, drugs and alcohol, sexual assault, coercion, child sexual exploitation, female genital mutilation (FGM), learning disability and modern slavery. All women under 18 have a safeguarding risk assessment, as do any vulnerable adults. Clients having a risk assessment are also offered video consultations.

Early provisional information received from independent sector abortion care providers in England and Wales shows that the percentage of safeguarding referrals has increased since the introduction of telemedicine between March and July 2020. This may be due to an increased number of women feeling more comfortable disclosing information over the phone or by video consultation, as well as the overall decline in the number of women purchasing abortion pills online. This second cohort of women are more likely to be vulnerable. Providers report that longer conversations can take place over telephone, which increases disclosure.
(https://authorea.com/doi/full/10.22541/au.160691768.87050587)

BPAS also asked patients about the EMA at home service in relation to safeguarding and domestic abuse. They found:
- 99% of clients said they were able to find a private space, with no interruptions, for the duration of the telephone consultation'
- 93% of clients said they would have felt able to share any concerns they have about their safety at home and/or in their relationship
- 24% of clients said that they discussed concerns about their safety at home with a member of BPAS staff.

In addition, as mentioned previously, a study published in September 2020 demonstrated that the rate of women seeking abortion medication outside the formal healthcare setting reduced significantly in the UK following implementation of the EMA at home model. The implication is that those previously too vulnerable to attend in-person, for example those in domestic violence situations, with physical or mental disabilities, or those who are socio-economically disadvantaged have been able to access regulated care through the EMA at home model, and therefore a larger proportion of women have been able to benefit from the safeguarding, counselling, and contraceptive services provided by regulated providers. Previously, this group of women may have missed out on these services altogether, in addition to exposing themselves to the additional risk of prosecution.
(https://srh.bmj.com/content/early/2021/01/11/bmjsrh-2020-200880)

No, the opposite. Women who are vulnerable are not necessarily able to speak more freely in a clinic, and it appears from evidence during the pandemic that the privacy of a telemedicine consultation at a time the woman finds convenient provides an atmosphere where the woman feels able to speak more freely. In addition, those women who have child care commitments and are dependent to working long and unsocial hours will find clinic access far harder than telemedicine consultations. It is known that the risk of domestic abuse rises in pregnancy, and an unwanted pregnancy is an especial risk. Hence, enabling rapid and easy access to abortion services through telemedicine will in itself reduce risks.
There is no evidence from research of the need for a clinic visit for any medical or safeguarding reasons. There may be individuals who still prefer a clinic visit, and for those such provision would be helpful, but they are a minority which may decrease further as the public becomes more familiar with telemedicine.

I would assume that during the appointment making stage, any safeguarding concerns would be acted upon.

It seems that the telemedical service results in more women feeling able to disclose safeguarding issues

There are clear benefits to requiring at least one in-clinic assessment, including overcoming many of the safety and safeguarding gaps with exist in remote services. They include:
Verifying the identity of the woman;
Accurately assessing the gestational age of the pregnancy;
Assessing clinical eligibility.

An appointment in person for the woman allows the clinician the opportunity to fully asses the woman's health and situation. This can highlight any medical concerns which can then be taken into account.
In a private consultation the clinician can also evaluate the woman's general well being and identify any concerns such as domestic violence, controlling relationships.
A personal appointment may also allow a better evaluation of how well the woman understands the procedure and ho to report any concerns.

There are clear benefits to requiring at least one in-clinic assessment, including overcoming many of the safety and safeguarding gaps with exist in remote services. They include:
Verifying the identity of the woman;

Accurately assessing the gestational age of the pregnancy;
Assessing clinical eligibility.
The risks to women carrying out a DIY abortion without visiting a clinic include:
Not adhering to the precise time intervals between two stages of the abortion;
Missing an ectopic pregnancy;
Emotional distress;
Domestic abuse.

Every woman is asked by abortion providers whether they are safe at home. This is a routine part of abortion care, no matter how or where care is provided. For instance, one NHS service in Wales gives women a safe word in their first interaction so they can raise concerns in the event they are not able to find somewhere private to speak.

The existing system of telemedicine, with in-person care where necessary, provides the best options for women who are victim-survivors of sexual violence or domestic abuse - particularly for those for whom leaving home for the length of time needed to attend appointment would be difficult or dangerous because their partner or family is monitoring their behaviour and travel. Telemedicine enables these women to access abortion care without risking their personal safety. Women in difficult circumstances are now more likely to seek regulated care and support in the knowledge that they will not be forced to travel to a clinic to access that help.

Services such as Women on Web, which have previously been contacted by women who were unable to access care as a result of their home circumstances and thus needed to receive (illegal) abortion care at home, report that requests for illicit online abortion medication from Great Britain fell by 88% during the initial months of telemedicine. As a result, vulnerable women are no longer risking life imprisonment by seeking to access care outside the legal, regulated healthcare system.

Abortion providers report that providing care remotely actually led to increases in the number of women disclosing problems at home. BPAS reported that in the first three months of their Pills by Post service, 10% of clients underwent an enhanced safeguarding risk assessment – a 12% increase compared to March 2020. For under-18s treated, there was a 25% increase in the proportion of clients referred to social services or the police compared to the same period in 2019. Clinicians providing abortion services report that telemedicine has made women more willing to disclose concerns about safety when in the privacy and familiarity of their own surroundings, as opposed to a clinical environment.

Telemedicine is not a barrier to the discussion of safeguarding or domestic abuse concern and abortion services continue to provide in-person care where telephone consultations raise safeguarding concerns such as safety or privacy at home, ability to consent, or wider safety concerns surrounding existing children or statutory concerns such as Female Genital Mutilation.

In reality, the possible benefit is negligible. Safeguarding can be effectively carried out remotely, as it is when telemedicine is used in other areas of healthcare. The assumption that in abortion care there is a greater safeguarding role is entirely misguided - it assumes that those accessing services are inherently vulnerable, which is simply not true. For the vast majority of those accessing care it is viewed as a routine treatment, no different to a course of antibiotics. It is inappropriate that we view abortion care as having a more significant safeguarding role.

Yes, disadvantages. There is no clinical benefit to having a statutory blanket requirement for women to make at least one visit to the service – studies have shown that remote services are as safe and reliable as in-person service. A return to a legal requirement for this visit would therefore be an unwarranted and politically-motivated interference that would disproportionately affect women from disadvantaged backgrounds. Abortion providers have continued to ask women whether they feel safe at home, and they report the same rate of safeguarding issues before and after the introduction of telemedicine services.

No – in fact, based on evidence from the past year, forcing clinic attendance is likely to result in reduced safeguarding disclosures and increasing numbers of vulnerable women and girls turning to illegal, unregulated sources of abortion medication online.
The existing system of telemedicine, with in-person care where necessary, provides the best options for women who are victim-survivors of sexual violence or domestic abuse, particularly those for whom leaving home for the length of time needed to attend appointment would be unsafe.
Abortion providers ask every client we treat whether they feel safe at home – both those treated in-person and via telemedicine. BPAS provides referrals to social services and the police, and we work with local charities and organisations to help women who need us. Since telemedicine started, we have found that clients are more comfortable disclosing domestic abuse and other issues to us because of their more familiar setting – enabling us to better support them, whatever their need.
In the first quarter of the BPAS Pills by Post, just under 10% of our clients underwent an enhanced safeguarding risk assessment – a 12% increase compared to March 2020.
These are undertaken as a result of a woman's personal circumstances, information disclosed to BPAS staff, the involvement of social services, concerns about human trafficking or modern slavery, legal requirements such as risk or presence of FGM, or the fact that they were under 18 years of age when presenting. This proportion suggests teleconsultations are not a barrier to identifying safeguarding concerns, and indeed some women may find it easier to disclose when in the privacy and familiarity of their own surroundings as opposed to a clinical environment.
BPAS has also evaluated our Pills by Post service specifically in relation to safeguarding and domestic abuse, with the following outcomes:
• 99% of clients said that they were able to 'find a private space, with no interruptions, for the duration of the telephone consultation'
• 93% of clients said they would have felt able to share any concerns they had about their safety at home and/or in their relationship

• 24% of clients said that they discussed concerns about their safety at home with a member of BPAS staff. These findings reflect the conclusion that telemedicine is not a barrier to the discussion of safeguarding or domestic abuse concerns. Where BPAS is treating an adult, there will be a discussion about whether she wants to involve the police or be referred into services such as a refuge. Many women will not want to pursue further support at that moment, although may engage once the termination is complete, and as with all other healthcare providers, we do not require women to engage with other services in order to provide care. However, where we believe there is a risk either to existing children or, if the woman opts to continue her pregnancy after her consultation, to her child when it is born, we are under a legal obligation to involve social services. This is also the case where we are concerned about girls and young women under the age of 18 who present to us. We also know that since we launched this service, women who have previously struggled to access in-clinic care, including women in abusive relationships, are no longer sourcing help outside the regulated healthcare system. Services such as Women on Web which have previously been contacted by women who were unable to access care as a result of their home circumstances and thus needed to receive (illegal) abortion care at home report that this care is no longer necessary and that women are instead seeking care via legal means.
The option of remote consultation enables a more flexible approach to access care. Accessing the service has been reported to be successful in enabling support for those with issues around safeguarding. https://www.msichoices.org/news/2020/6/marie-stopes-uk-sees-a-33-rise-in-domestic-violence-reports-under-covid-19-lockdown/
The risks to women carrying out a DIY abortion without visiting a clinic include: Not adhering to the precise time intervals between two stages of the abortion; Missing an ectopic pregnancy; Emotional distress; Domestic abuse.
No. I believe that there are benefits to women's safety in not forcing women to attend clinic. Some women may benefit from attending clinic, and they can still attend with the new measures in place.
no. probably the converse as contact can be made more privately online
The concern that is sometimes expressed about home use of abortion medications is that it might remove the possibility of the consulting medical professional to speak to a patient alone who might be able to disclose any concerns about their welfare / whether they are being pressured into abortion. The first important point to note is that allowing home-use of abortion medications does not necessarily mean that all people will refrain from having their consultation in-clinic when they have a choice, and it does not prevent practitioners from inviting patients in where this is believed to be necessary. Home use of the medications and the consultation (being remote or in-person) are different aspects of the care pathway. Therefore, any concerns about the quality of remote consultation should not be taken as a reason to limit home use of abortion medications. There are not sufficient concerns in any event to make attendance at a clinic mandatory, rather than a matter of choice for service users, and practitioners using their clinical discretion can invite patients into clinic when they feel it necessary. Another important point to make before considering the quality of remote consultations is that people in difficult circumstances, including abusive households, still need access to abortion care even if this particular interaction with medical professionals does not result in them getting the additional help that they need (Parsons and Romanis, forthcoming). Many actually report that their abusive partner or family means that attending a clinic in-person is not an option for them at all, and thus they bought abortion medications online (Aitken and others 2018; Milne 2021). There is no guarantee that mandatory in-clinic requirements mean that they will attend, they are more likely to find it harder to engage with this system, or that in-clinic they will feel able to disclose their situation. With remote care, it is more likely that these people will be able to access the care that they need lawfully. Ultimately that women are able to access abortion to end unwanted pregnancy when they are in an abusive environment is incredibly important as without this they may be less likely to be able to leave in the longer term, and it is likely that they will experience more violence as a result of being pregnant (Cook and Bewley 2008). In many cases of unwanted pregnancy in an abusive home, remote abortion consultation (and at-home care) will preserve these women's health, and on-balance their welfare in the circumstances. Furthermore, there are some reasons to believe that remote consultations do not necessarily limit a practitioner's ability to perform any necessary safeguarding that falls within their usual remit of doing so as a medical professional. Data from the British Pregnancy Advisory Service saw an increase in the numbers of their clients that went through an enhanced safeguarding assessment in the new system of remote consultations (BPAS 2020). This reflects the realities of the point addressed above – that actually people in difficult situations are much less likely to be able to engage with care when there is an in-person requirement, and the fact that some people may find it easier to disclose sensitive information in an environment that they are more familiar with (or in another space that is safe to them) rather than alien to them (Parsons and Romanis, forthcoming). This might be particularly true in cases where a person does not live with their potential abuser. Clinics can be intimidating for some, and without the fear of being seen by an abusive partner or family accessing a clinic a person may engage with the consultation better and feel able to raise some welfare issues. This will, of course, be very person-dependent, but it is important to acknowledge that in some instances this is equally possible as the idea that a person does not engage because they are in the home. Finally, I find it problematic that there is a large emphasis placed on safeguarding and safety with regard to accessing abortion. The concern is overemphasised so as to suggest that all people seeking access to abortion care must be in a difficult situation, which is not the case as abortion is a service that is accessed by one in three women in England and Wales during their lives (Department of Health and Social Care 2020). As stressed, even for people with additional safeguarding needs, ensuring they have access to the abortion they need will protect their physical

health and there is no guarantee that an in-clinic requirement protects their welfare at all. References: Aiken, A and others. 2018. 'Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain,' Contraception 97 (2): 177-183. British Pregnancy Advisory Service. 2020. 'Pills by Post: Telemedical Abortion at the British Pregnancy Advisory Service (BPAS).' Available at: https://www.bpas.org/media/3385/bpas-pills-by-post-service.pdf Cook, J and Bewley, S. 2008. Acknowledging a persistent truth: domestic violence in pregnancy. Journal of the Royal Society of Medicine 101 (7): 358-363. Department of Health and Social Care. 2020. Abortion Statistics for England and Wales: 2019. https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2019 Milne, E. 2021. 'Banning safe home-use abortion pills will leave more women in crisis.' https://theconversation.com/banning-safe-home-use-abortion-pills-will-leave-more-women-in-crisis-154594 Parsons, JA and Romanis, EC. Forthcoming. Early Medical Abortion, Equality of Access and the Telemedical Imperative. Oxford: Oxford University Press.
absolutely essential to see a mental health professional. if the clinician is not professionally qualified accredited as a mental health professional then they will lack the expertise to explore the emotional impact of termination.
I do consider that there are benefits in relation to safequarding & women's safety in requiring women to make at least one and preferably both visits to be assessed by a clinician. They can assess whether it is safe for the woman to take these drugs - the correct age of the baby, that there is no chance of an ectopic pregnancy & that the drugs are taken at the correct time interval.
I believe it is essential that the woman is seen by the clinician before and after taking the tablets to determine the gestation of the pregnancy, ensure compliance and any possible complications.
There are very definite benefits to seeing a clinician for assessment as already referred to including: Accurate assessment of pregnancy dates Assessment of the woman's physical health Assessment of the woman's mental health Spotting of any possible safeguarding issues or issues of coercion Discussion of risks involved Discussion of appropriate birth control methods for the future During an undercover investigation last year, abortion providers sent out 26 DIY abortion packs to all 26 women mystery clients. The callers were able to obtain pills using false NHS numbers and unverified gestational ages. The reality is that abortion providers are sending out DIY abortion kits and they have no idea who is using them or when.
Of Course it would It's particularly important that it be a 1;1 interview without partner, parent or other person present to avoid coercion and illegal termination and for the safeguarding responsibility of the provider for the women. There she can disclose at risk symptoms and situations freely for her own safety Also that the practitioner can ensure that it is actuallly for her and not someone else
Yes. Experienced clinicians can identify face to face any medical issues and the actual gestation of the pregnancy.
The benefits are obvious in that a lot of the risks associated with home abortion, like confirming the identity of the woman concerned and ensuring that the criteria are met e.g. number of weeks gestation, would be covered. An ectopic pregnancy might be picked up; it is more likely that the time interval for taking the second pill would be accurately kept. Additionally, coercion and / or abuse are much more likely to be picked up.
Any woman who is pregnant should definitely have good medical supervision and support particularly during Covid-19
Various risks such as ectopic pregnancy can be missed if a woman is not assessed by a clinician. Clinician assessment can advise correct use of these powerful drugs and help minimise the risk of coercion into home abortion.
There are clear benefits to requiring at least one in-clinic assessment, including overcoming many of the safety and safeguarding gaps with exist in remote services. They include: Verifying the identity of the woman; Accurately assessing the gestational age of the pregnancy; Assessing clinical eligibility. The risks to women carrying out a DIY abortion without visiting a clinic include: Not adhering to the precise time intervals between two stages of the abortion; Missing an ectopic pregnancy; Emotional distress; Domestic abuse.
Yes, I do. At least one visit would enable a woman's identity to be determined, the stage that the pregnancy has reached, whether there are any underlying medical conditions, such as an ectopic pregnancy, whether there is any form of domestic abuse/coercion, and any mental health issues.
I believe it is essential that a woman should see a clinician, to ensure the person has properly considered their course of cation. Other potentailly unknown issues could be indentified by a clinician, making the process safer. Abortion providers have been found to send out DIY abortion packs without checking the patient's details, risking the medication ending up in the wrong hands.

Yes.

Visiting the clinic means the clinician can verify the identity of the woman, accurately assess the gestational age of the pregnancy, pick up on any potential complications (eg. ectopic pregnancy), and assess her clinical eligibility.

YES.
The benefits include
- opportunity for in-person assessment by the clinician
- some measure of protection from coercion or domestic abuse
- opportunity for a woman facing this issue to receive some form of feedback and assessment (if not necessarily advice) which would help her deciding her course of action
- opportunity to seek advice on medical matters if she wishes

Yes, as above.

Requiring women to be assessed by a clinician has clear and obvious benefits to women's safety. Women being certified for an abortion without seeing a doctor in person significantly increases the risk of potentially life-threatening conditions, such as ectopic pregnancy, being missed. Ensuring women wanting an abortion go to a medical setting at least once reduces this risk.

Removing the administration of abortion pills from a medical setting supervised by professionals causes a significant risk that abused women could be coerced into an abortion. Evidence from NHS boards shows that the Covid rules have sped up the abortion process. This could lead to women in crisis pregnancies being rushed through a highly traumatic process – especially those who are alone and vulnerable.

It has been suggested that a significant proportion of those taking prescription drugs do not follow the recommended protocols.[1] This highlights the dangers of leaving women to take strong drugs like abortion pills unsupervised. Advice from a clinician helps mitigate the risk. During an undercover investigation last year, callers were able to obtain pills using false NHS numbers and unverified gestational ages. Abortion providers sent out DIY abortion packs to all 26 women mystery clients.[2] Home abortion kits are being sent out with no idea who will use them.

[1] Hovstadius, B and Petersson, G, 'Non-adherence to drug therapy and drug acquisition costs in a national population – a patient-based register study', BMC Health Services Research, 11 (326), 2011
[2] Abortion at Home: a Mystery Client Investigation, Christian Concern, July 2020

Yes. Abortion providers have no way of knowing in the case of remote consultations if the request comes from the woman to whom the pills are administered or if a coercive partner or family member is present and exerting pressure to abort. Abortion may even be physically coerced (for example, the pills administered covertly) when pills are obtained remotely, as has certainly happened (see Charlotte Lozier Institute, Medical and Social Risks Associated with Unmitigated Distribution of Mifepristone: A Primer).

Benefits include:

Being able to verify the identity of the woman;
Being able to accurately assess the gestational age of the pregnancy;
Being able to assess clinical eligibility.

Risks to women carrying out a DIY abortion without visiting a clinic include:

Not adhering to the precise time intervals between two stages of the abortion;
Missing an ectopic pregnancy;
Emotional distress;
Domestic abuse.

Safeguarding and women's safety
Detection of coercion a well known risk and cause for abortion.
Lay people should never be totally responsible for a medical procedure.

• The new arrangements can lead to a trivialising of the value and worth of pregnancy and subsequently of abortion. Women will find themselves able to dismiss the emotional and physical impact of a pregnancy and the value of their ability to reproduce. At least by keeping abortion medicalised it can be viewed as more than just taking a couple of pills.
• It's more than simply women attending a clinic; it's the fact that this allows them to be seen by a health professional and an accurate gestational age confirmed. It's also about having relevant pregnancy/health tests and an emotional assessment being carried out in person face to face.
• We are concerned about women and young girls in abusive relationships being coerced or even threatened into taking these pills by an abuser or groomer to hide their crimes . When abortions are procured without the physical input of doctors we cannot ascertain for sure if the pills are to be used by the caller or if they are being obtained for someone else.

There is a clear and obvious risk in women being administered an at home, medical abortion without seeing a doctor in person. It significantly increases the risk of potentially life-threatening conditions, such as ectopic pregnancy being missed, a complication that would be discovered with proper, in person, clinical care.

It has also been suggested that the general public do not properly adhere to guidelines relating to taking prescription drugs. The study by BMC (BMC Health Service Research), states that "patients use less medication than prescribed or prematurely stop the therapy" (Hovstadius, B. and Petersson, G., 2011. Non-adherence to drug therapy and drug

acquisition costs in a national population - a patient-based register study. BMC Health Services Research, 11(1).). When considering the fact that taking the medical abortion pills on or after the 9 weeks and 6 days post-gestation period significantly raises the possibility of medical complications, discrepancy with how women follow the home abortion's protocols poses a concerning safety risk. Due to the only form of consultation being through telemedicine, the service providers have no way in confirming the identity of the woman requesting the medical abortion pills. They have no way in knowing whether the woman is requesting the pills for herself or another person, or whether the woman requesting the pills is doing so because of the pressures of their abuser. As a result of this lack of confirmation during the telemedicine consultation, there is a concerningly low regard for the safeguarding of the woman's safety with this legislation. With an in person visit, service providers would be able to properly read such things as the intentions of the woman, noting body language that could give the clinician a better understanding of how to supervise the woman.
It is good to at least have this one visit but do not feel this is enough.
I would suggest there are considerable benefits in relation to safeguarding and women's safety in requiring them to make at least one visit to be assessed face to face by a clinician. Although abortion should be an option available to ALL it is never the less a life changing decision in any circumstances and not to be taken lightly. Every woman regardless of her situation or background deserves the right to unbiased counselling and given every support before making HER decision. The risks involved must be highlighted and sufficient advise given to follow the protocol recommended in using these potentially dangerous drugs. The clinician can make a professional judgement on the stage of pregnancy and therefore avoid many of the risks more common in later stages
A woman has the right to counseling when making such an important decision. Sexual violence may be a feature of the pregnancy and the Law must be enacted upon. Again, a woman may be feeling forced into the decision. An examination can ascertain the length of the pregnancy: her dates may be wrong. Complications may be apprehended and interventions made: an ectopic pregnancy is a life threatening occurance. My answer is ""no"", I consider there are no benefits.
There are benefits with both approaches.
Yes, for the risks I give in my answers to Q1 and Q2 above. The risks are of late abortions due to inaccurate dating (whether unintentional or intentional), including those over 24 weeks' gestation that would not meet section 1(1)(a) of the Abortion Act 1967. There are risks of adverse events associated with incorrect dating, or of ectopic pregancies. There are also risks of coerced abortion. It is impossible to say who might be at the other end of a telephone or video call as well as the patient, if the clinician asks her if she wants to go through with abortion. The ways to mitigate these risks are to scan every patient to date the pregnancy accurately and to confirm an intrauterine pregnancy, and to ensure every patient has a private face to face conversation with a clinician.
I don't know.
There are clear benefits to requiring at least one in-clinic assessment, including overcoming many of the safety and safeguarding gaps with exist in remote services. They include: - Verifying the identity of the woman; - Accurately assessing the gestational age of the pregnancy; - Assessing clinical eligibility. The risks to women carrying out a DIY abortion without visiting a clinic include: - Not adhering to the precise time intervals between two stages of the abortion; - Missing an ectopic pregnancy; - Emotional distress; - Domestic abuse.
Yes. As described above, the chances of clinic staff detecting a safeguarding issue, or of a woman or girl disclosing an issue with e.g. coercion, pressure, IPV, other domestic abuse, exploitation or ambivalence can only be greater in a clinic, especially if the staff have the training, confidence and support to screen for these issues. For example, seeing the woman's non-verbal communication, giving her additional opportunties to alert staff (as some clinics do), being able to see the person who accompanies her (e.g. is a 25 year man bringing his 15 year old girlfriend for a termintation, or is it a mother who does all the talking, and shuts down her young daugher), can help staff to take appropriate action. While there is evidence that such opportunities have often been missed in the past in in-person appointments, there is far less chance they will even arise via remote consultations. Ideally, clinic appointments would be improved from pre-pandemic standards, to provide more meaningful safeguarding.
There is no clinical benefit to having a statutory blanket requirement for women to make at least one visit to a service: the evidence presented in this consultation response shows that a remote service is as safe and as effective as an in-person service. Reinstating a legal requirement for women to make at least one visit would therefore represent an unwarranted and politically-motivated interference that would disproportionately affect women from disadvantaged groups. Similarly, there is no benefit in relation to safeguarding to having a statutory blanket requirement for women to make at least one visit to a service: abortion care providers are bound by law and professional guidance to act on any safeguarding concerns, and so everyone who access abortion services is asked if they feel safe at home, whether

that is via telemedicine or during a clinic visit. Abortion providers have reported that better privacy at home enables women and pregnant people to talk more freely, and they report the same rate of detection of safeguarding issues before and after the introduction of telemedicine. Face-to-face appointments are still available for women who feel they need them and for those about whom providers have safeguarding concerns; making recent regulatory changes permanent would not change this.
See answer for Question 3.
Women seem to talk more openly when consulting over the phone form their own home or chosen environment - and I have found that to be a posiitve enhancement of the majority of the consultations that I have on a day-to-day basis. I feel a greater sense that my patients can express their true feelings - including ambivalence and uncertainty when they feel safer and more relaxed in their own environment. In general the vast majority of women are perfectly able to understand the small degree of risk of later gestation/undiagnosed ectopic if a no-scan abortion pathway is indicated, and we wish to be allowed to use our clinical discretion to offer scans to those who are either anxious or unable to understand or accept that risk - or of course if clinically indicated. Since before 2011 the RCOG have said universal datings can are noted necessary and NICE 2019 supported this. Clinicians in abortion care and most other services have adapted to remote consultations and learnt to apply our clinical expertise in identifying safeguarding concerns but simply using a different medium of communication. As already hinted our patients often seem more able to disclose concerns or sensitive or difficult information when they are in a familiar environment. We always ensure the patient is not being coerced around her pregnancy decision through various mechanisms that enhance safeguarding.
Yes. In a clinic, there is a possibility that a woman can tell someone that they don't want the abortion they are being forced to ask for. The clinic can check the identity and stage of pregnancy of a woman seeking an abortion. In a clinic, possible medical complications can be anticipated and dealt with. The clinic can make sure that the correct time between the two stages of abortion is adhered to. At a clinic, the emotional distress of carrying out this procedure, alone, at home can be made less.

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?

It's so dangerous to give people the option to do this at home, to those who may have mental disabilities or other learning problems would be absolutely abhorrent ! Typical people are even risking their own lives !
A conscientious objection to abortion could be compromised for any hospital staff who become involved in posting out abortion pills to women. For example, staff who are otherwise not involved in abortion could be asked to prepare packages containing abortion pills.
Disabled pregnant women are likely to require special care. Remote abortion takes away the opportunity for a healthcare professional to detect domestic abuse. A conscientious objection to abortion could be compromised for hospital staff who are made to post out abortion pills to women. Staff not normally involved in the abortion process could be asked to prepare packages containing abortion pills.
As I understand it, use of home abortion is already anathema to all serious followers of the major world religions, and a standing insult and marginalisation for any citizen holding those beliefs. United States experience suggests that the active promotion of abortion unduly affects ethnic minorities - see the decrease in the African American population in recent decades. If we connect this with the fact that ethnic minorities often belong to the D and E socio-economic groups and that agencies such as the BPAS seem to regard mass abortion as a panacea for poverty, home abortion can be seen as a tool of politically motivated individuals for minimising any element of the population found undesirable. My bad experience of this attitude influencing even otherwise neutral persons was instrumental in my withdrawal from the Community Health Council. All (except myself) expressed regret that abortion was not being taken up in comparable numbers by those in the D and E socio-economic groups. No sense of a personal crisis and the worth of the individual there. Those ""neutral"" people had come to see abortion as an element in social planning. A quarter of babies in the UK being killed before birth looks very much like the same scenario, and certainly inexplicable on purely medical grounds. In conclusion, I would claim that the approval of home abortions are yet another example of how administrations and governments can't in actual fact give a damn about religious and ethnic minorities, and the insult offered them by the readiness to have their babies killed before birth. As a current example of religious intolerance and covert racism it is difficult to beat. Quite apart from the humanitarian aspects of the case, home abortion, like abortion in general, is partisan, bigoted, narrow-minded, and totally unresponsive to the real needs of women of childbearing age. The other ""solutions"" to a problem pregnancy should be presented with at least an equal vigour, and women never ever expected to violate their conscience. Home abortion with its apparent easiness delays of course the implementation of such a non-discriminatory policy, maintaining the intolerance and racism and disregard of the poor inherent in an abortion-promoting regime.
A disabled pregnant woman needs special care over and above that afforded to able-bodied women. Also, there is far greater possibility of a disabled woman being abused by a controlling partner. This would be all the more the case if EMA were to be made permanent.
Women are now given the option if no complications/issues/triggers/medical history, to have their pills and contraception sent by courier. This has been seen by women as convenient, in that they do not have to attend clinic. This then does not effect their work schedule or them having to find child care. Women have been quite shocked when we offer this service and found this to be a triump in Abortion treatment.
I think it will have a positive impact and reduce discrimination. Minority groups might feel more apprehension about being assessed by a clinician and are therefore more likely to access services if they can use them from home
As Q 5
It is wise to be sure that adherents of one religion do not impose their views on persons of another religion. I have in mind the scenes outside abortion clinics in the United States. Disabled people need particularly gentle handling - the psychological effects may be greater in some disabled people, depending on the disability and the circumstances.
i do not know the answer to this. however, any chnage to a permanent measure should enable women to have the choice of which service they prefer - in case home situation is not suitable for home use of pills
Very badly. Disabled pregnant women are likely to need special care, and open to exploitation under the DYI abortion scheme. Pregnant women who are abused are also at greater risk from abortion. Home abortions both remove the opportunity for detecting abuse via a private consultation in a clinic or hospital and makes it easier for abusers to force a women into abortion. Religion: A conscientious objection to abortion could be compromised for hospital staff who become involved in posting out abortion pills to women. They should not be put in this position, we are already short of hospital staff and issue like this could stop people from entering the profession.
I think the impact of making home use of these pills permanent could have a devasting impact on certain people groups/communities. I think it's dangerous for people to have such easy access to them and then to be unsupervised when taking the pills. I am sure there are different side effects that disproportionately impact people from different ethnic backgrounds which makes just it more disastrous.

Making abortion a simple procedure, at home, does not take into consideration many communities who find abortion offensive in the first place. It is entirely inappropriate as far as disabled are concerned. It is most offensive to those who realise that their own mothers would have been offered abortion, simply because of their disability, whether down's syndrome or cleft palate etc.
The disabled need extra care, missing in DIY? Increased chance of abuse as referred to in previous answers Abused women at greater risk from abortion, less ante natal care? Religious and coscientious staff if are forced to add abortion pills when preparing care packages
This would be absolutely dreadful every life is worth saving and has a right to life
Abortion always discriminates against the disabled who are killed before birth on that basic. In terms of the mother, it will give even less support to those who need extra support not less; the disabled, those who speak limited English etc. In lockdowns, women will end the pregnancy surrounded by family, even children. Traumatic all round.
Women with disabilities are likely to need greater care when pregnant and terminating it at home will bring greater risks, as well as possible coercion to have an abortion.
Medical staff dispensing these pills could be pressured into doing so despite having religious objections to having any involvement in abortion. Abortion is a life-or-death matter; it cannot be taken lightly.
Disabled pregnant women are more likely to need special care and they are more vulnerable to exploitation under the DIY scheme. There could be an increase in abuse among the vulnerable and allow abusers to cover their tracks more easily. Medical professionals could have their conscientious objectivity compromised if theyre asked to post pills or package them up for posting.
Sending abortion pills through the post is extremely sinful and should be stopped.
There is an absolute right to life. It shouldn't matter what disability or religion a person is or has. Abortion shouldn't be as easy as taking both pills at home. People need support and care, certain communities where abortion is considered wrong will find their women further isolated by these measures as the clinical consultation may have been the only meaningful discussion they have regarding their choice.
Medical abortion has a negative impact on all groups because it is legalised homicide. Specifically it will also negatively impact mothers from poorer households who can more easily abort their children. The option of easy abortion encourages greater promiscuity because if contraception fails the mother can just pick up the phone and order an abortion. Greater promiscuity increases the risk of sexual disease in males and females.
Women with disabilities can be more vulnerable to exploitation. Removing the obligation for a woman to attend the clinic, means that the opportunity is removed to assess her situation properly and thoroughly by seeing her in person. Some needs and vulnerabilities are not detectable by a phone call, and may only be picked up by seeing the woman face to face. This is necessary to ensure that she is not being coerced into the abortion, or the subject of Domestic Violence/Intimate Partner Violence. Staff working in hospitals who conscientiously object to abortion may find themselves compromised by being asked to perform tasks relating to the pills by post scheme, for example, packaging up the pills to be posted to the women.
DIY abortions increase the risk to disabled women who might be vulnerable to exploitation and abuse. Abusers who know DIY abortions can be accessed by post are able to conceal the abuse and without proper consultation those abused are at the same risks of complications as non disabled women and without the means of voicing their distress and without a member of a medical team to protect their interests and safety. This is an extremely worrying point and must be given vital consideration. Religious beliefs must be considered. Someone objecting to abortion might become involved in posting out the abortion pills when they would otherwise not be involved in any aspect of this treatment.
This would have a bad impact on many different communities in society. The devaluing of human life to the extent of talking in terms of value for money and convenience to abort will have detrimental effects in all areas of social cohesion.
It is a biological fact that a human life with potential begins at conception...any retreat from that would be devastating for those who believe that fat.
I believe making permanent the use of medical provision of both pills at home would have a detrimental impact on those of minority backgrounds and those with disabilities. I feel the patients might be coersed using this remote service and may not fully understand the impact of home abortions.
Disabled women are likely to need special care they too are at risk of abuse. Abusers knowing that pills can be obtained through the post are able to conceal their abuse more easily. Women seeking abortion are in a higher risk category for domestic abuse and victims of abuse are at risk of being forced into abortion. Hospital staff who hold conscientious objections to abortion might be asked to compromise these beliefs by being asked to prepare packages containing abortion pills.
This is a clear violation of the right of the unborn child who have no voice in this society. This is an easy fix for those who wants to enjoy life or make their lives easier, who doesn't want to take responsibility for their actions. This will degrade the moral values of our society as unbirn lives are easily ended through DIY abortions. The essence of responsibility for one's actions and sacrifice for an innocent life or even lives the of those who are looked at as "frail and burden " is totally in oblivion.It applauds the "culture of death" since no society is worst than a society that allows a mother to kill her own flesh and blood.It seems to me that our society grieves more for the death pf our pets than the death of an innocent life in tge womb. I could go on and on...
Quite disastrous. Sex should be between 2 CONSENTING ADULTS. People with ethnic or religious backgrounds need to be respected for their views and their views taken into account, as should people with disabilities.

Does no one consider the frequency of an inability to conceive in those women who have had abortions in the past especially when abortion is used as Birth Control? iT IS VERY COMMON.
Home abortions remove the protection afforded to a woman who is subjected to domestic abuse which medical consultation could provide, and studies demonstrate that women seeking abortions are more likely to be victims of intimate partner violence. Women with any degree of disability naturally require greater medical care to be available. Hospital staff who conscientiously object to abortion may well be expected to prepare and send out abortion pills.
if you really want to kill your future population by giving them easy access to pills - well my congratulations! that's the ideal path to self destruction and harm to people in general, freedom is great but if don't any limits or boundaries it will lead to a failure, please look and think backwards what happened and learn the lesson from it...
Greater accessibility also brings greater responsibility for the providers of this service to consider the consequences on these groups of people. Statistically more black women have terminations so may be under greater pressure to access the service. The service provider must take greater safeguarding steps with these clients.
Pregnancy • Disabled pregnant women are likely to need special care. Disabled pregnant women may also be more vulnerable to exploitation under the DIY abortion scheme. The following points on the risks for pregnant women would apply equally to disabled pregnant women. • DIY abortions can increase abuse for pregnant women. Pregnancy can be a trigger for domestic abuse, and existing abuse may get worse during pregnancy or after giving birth. Abusers who know that women can get abortion pills through the post will be able to cover up their abuse more easily. High levels of abuse have been recorded during the pandemic. • Pregnant women who are abused are at greater risk from abortion. In a study of London clinics, there was a six times higher rate of intimate partner violence (IPV) in women undergoing abortion compared with women receiving antenatal care.Women seeking abortion are in a higher risk category for domestic abuse, and victims of abuse are at risk of being forced into abortion. Home abortion both removes the opportunity for detecting abuse via a private consultation in a clinic or hospital, and makes it easier for abusers to force a woman into abortion. Religion or belief • A conscientious objection to abortion could be compromised for hospital staff who become involved in posting out abortion pills to women. For example, staff who are otherwise not involved in abortion could be asked to prepare packages containing abortion pills.
I think that abortion is incompatible with catholic faith.
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Too easy to complete people could be forced into making this decision by others for various reasons.
This would have a positive impact on all communities as it reduces the risk to travel and to arrange escorts. Staff would have more time to spend in face to face consultations with those who really need it.
I am against this on many levels. Mothers may be co-erced into having an abortion by members of their family especially where pregnancy outside marriage is a dishonour to the family. Abortion is made too easy by just taking pills which arrive through the post. Some people may be even given these pills without either their knowledge or permission. This is not acceptable at all.
Situation of every person is different but we know that in the 21st century there are still incidents of domestic abuse, mental illnesses, various disabilities etc. In some cultures, even though they live in Europe, it’s desired for first child to be male. How can we protect the vulnerable woman from being forced to take abortion pills, sometimes in much later stages of pregnancy than intended, if we won’t secure for them confidential one to one discussion with a health professional?
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I think this could have both positive and negative impacts on people from different backgrounds. For example, for some religions where abortion is frowned upon, the women may feel more comfortable in asking for these pills without having to attend the hospital. However some people may be afraid of taking these pills at home as they won't have the same emotional support and may not have a 'safe space' at home to do this.
It will make services more accessible and allow women to manage their healthcare in a way that is suitable for them
Given their already vulnerable condition, the dangers of possible coercion for disabled women are increased from what is true under this scheme for every women (see above). In settings where religious traditions place women under the 'authority of their husbands or families, an online service increases risks of coercion. The rights to conscientious objection of medical staff from certain religious backgrounds will need to be robustly protected (sending out abortion pills by post constitutes immediate participation that would be unacceptable).
It saves women from a potentially stressful and painful experience happening in public
As has already been reported, home use increases accessability for women with disabilities, those living in poverty and women who may face cultural or family pressures to continue with an unwanted pregnancy.
Again coercion. Sex selection. No post-abortion support both physical and mental health are at risk.
Take as an example cities in America where there are a disproportionate number of abortion clinics in black neighbourhoods, and where half of pregnancies in black women result in abortion. I guess these clinics would really start to lose money unless they put up the price of the pills. I was about to call it medicine, but medicine is meant to preserve life. The question is more, who is it who wants to encourage more black babies to be aborted in American cities. Making it easy to have an abortion at home after the emergency situation alters would make it easier for a young person whose parents' religious views are different from their own to have an abortion. Some may consider this a good thing. Most parents would disagree. Interesting that you mention disability, abortion is the greatest discrimination against people with disability. Wow! What a question to ask!! You can easily get an abortion up to birth for any baby with a disability, hardly any need for a way to make it easier... oh, I guess you are talking about those who make it to birth who may later want to have an abortion themselves?
It would make it easier for those groups to access early and discretely
People who already find it difficult to access, or are actively discouraged from accessing, health and social services, should be encouraged and assisted to do so where it is important and beneficial, rather than simply making it easier for them to stay away
I feel it would be vital for the women to have the option of having both pills at home as, they are in control of when they commence their treatment in a safe environment. Why would we want to change this temporary measure back, it has worked extremely well, women/girls have contacts if any concerns or unsuccessful treatment. Those that have disabilities and also have children, to bring them to a clinic seems unfair as it has proven, having both pills at one visit or courier works well. Those from different ethnicities and religious backgrounds want to deal with their abortion treatment as soon as possible delaying this treatment can have a big impact on their wellbeing and mental health.
The examples given in the question are enough to illustrate the sensitivities and complexities involved to show that a medical professional or health professional needs to be involved in ensuring safety, awareness and clarity in decision making.
Age – younger women and girls under 18 are disproportionately likely to lack the ability to travel for care as a result of lack of access to private transport, or the money to travel on public transport. During the pandemic there were also sizeable numbers of student-age women living at home with their parents and seeking to conceal their pregnancy and abortion. Telemedical abortion services increase accessibility for this group, and enable them to better preserve their privacy. • Pregnancy or on maternity leave – This consultation should focus on the needs of pregnant women – and their ability to access care without unwarranted and nonevidence based intervention or regulation by the government. • Disability – Women with both physical disabilities and certain mental health issues may struggle to access in-person medical care, particularly where they don't have their own means of transport or require an escort to attend a clinic. Some women may be unable to travel at all. Without telemedicine, there is a real risk that these

women are forced to turn to illegal online options because they cannot access care within the formal healthcare system. • Race and Religion/Belief - Members of all communities in the UK access abortion services, even where their cultural or religious background disagrees with abortion access. These women are disproportionately likely to need to access care privately and without the need to travel – which is only ultimately available via telemedicine. • Sex – 1 in 3 women will access abortion care during their life. The legal provisions surrounding the accessibility of care are a fundamental part of women's healthcare and the exercise of women's rights in this country. Abortion should not be subject to unnecessary, politically-driven restrictions which are not in place for other forms of gender-neutral healthcare. Women have the right to access abortion, and should have the right to access high-quality, evidence-based care.
Women with physical disabilities and mental health issues may struggle to access in-person medical care.
It would give women greater freedom to choose if, for example, they are disabled and could not attend without help or if they come from a background where their freedom of movement is restricted.
Would make it more accessible to those unable to travel or ashamed of their situation.
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As long as memory problems or interference by religious objectors are not involved, then there should be no impact.
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The service makes home use pills incredibly beneficial to a range of women from varying backgrounds. For example, those who are unable to leave the house without the assistance of others are now able to carry out the procedure without having to inform others as it can be completed independently. Moreover, those that come from a religious background whose family does not support abortion or those in an abusive relationship for example are now able to access these services in a way that does not arouse suspicion or alert those around then allowing them to make the decision that it right for themselves without having to consult those around them that would not be supportive of their choices. Moreover, those who live rurally or would have access travelling to appointments are also benefitted by the use of at home pills.
Positive impact, lack of requirement to travel to a clinic that is often a distance from home
It will make a huge difference, privacy and convenience are key factors that will allow greater access to those that really need it.
Permanent home use of both pills will help young women maintain their reproductive autonomy. Younger women and girls under 18 are disproportionately likely to lack the ability to travel for care as a result of lack of access to private transport, or the money to travel on public transport. During the pandemic there were also sizeable numbers of student-age women living at home with their parents and seeking to conceal their pregnancy and abortion. Telemedical abortion services increase accessibility for this group, and enable them to better preserve their privacy. It will also benefit women with disabilities. Women with both physical disabilities and certain mental health issues may struggle to access in-person medical care, particularly where they don't have their own means of transport or require an escort to attend a clinic. Some women may be unable to travel at all. Without telemedicine, there is a real risk that these women are forced to turn to illegal online options because they cannot access care within the formal healthcare system. A permanent change will also enhance accessibility among different racial and religious groups. Members of all communities in the UK access abortion services, even where their cultural or religious background disagrees with abortion access. These women are disproportionately likely to need to access care privately and without the need to travel – which is only ultimately available via telemedicine.
I think it would provide more freedom of choice
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In all aspects of sexual and reproductive healthcare, F2F booked and walk in access should be available to vulnerable groups in addition to serving the vast majority of uncomplicated cases in a streamlined fashion that gives services mor e time to tailor provision to the needs of those women who require that bit more.
there are always communities that will benefit from this service being made permanent. some communities would rather deal with a medical termination without any personal input from clinicians for religious belief. some patients with certain disabilities may require medical input throughout a termination, however some disabilities could result in a patient being afraid of a hospital setting, and therefore a home setting being supervised by a trusted carer/ staff member would be the best scenario for them.
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I think the differential impact is vast and requires very careful consideration.
No comment
It is a concern that as a society we do not value difference and therefore babies who are diagnosed with disabilities or difference, such as Downs Syndrome, in the womb, are more likely to be terminated. This happens anyway, but in my opinion, is likely to increase if home abortion becomes more permanent. It is also a concern that babies may be terminated for life style choices - such as biological gender. Currently this is not permitted in this country, but that would not be able to be policed if abortion is taking place in the home.
Disabled pregnant women are likely to need special care. Disabled pregnant women may also be more vulnerable to exploitation under the temporary measure abortion scheme. The following points on the risks for pregnant women would apply equally to disabled pregnant women. Abortions (under the temporary measures) can increase abuse for pregnant women. Pregnancy can be a trigger for domestic abuse, and existing abuse may get worse during pregnancy or after giving birth. Abusers who know that women can get abortion pills through the post will be able to cover up their abuse more easily. High levels of abuse have been recorded during the pandemic. • Pregnant women who are abused are at greater risk from abortion. In a study of London clinics, there was a six times higher rate of intimate partner violence (IPV) in women undergoing abortion compared with women receiving antenatal care. Women seeking abortion are in a higher risk category for domestic abuse, and victims of abuse are at risk of being forced into abortion. Home abortion both removes the opportunity for

detecting abuse via a private consultation in a clinic or hospital, and makes it easier for abusers to force a woman into abortion. Religion or belief • A conscientious objection to abortion could be compromised for hospital staff who become involved in posting out abortion pills to women. For example, staff who are otherwise not involved in abortion could be asked to prepare packages containing abortion pills.
I can only see negative impacts for both individuals concerned and society in general if this becomes normal.
I do not agree to make it permnant as I don't agree with the logic of it all. You need to have support through such a hard decision and us a clinician need to be there in person rather than on a phone.
Religion is not a sound basis for evaluating impact of provision here. Individual women are in all communities and this provision is for them and their GPS to decide.
The aspects of concern regarding coercion and mental health cross all boundaries of ability, enthnicity and religion. There should always be proper consultation therefore, regardless of these aspects
Young women and women who live rurally are likely to have more trouble travelling to a clinic. THis would also apply to women with disabilities or mental health problems. Home use of the pills means all women have much more equal acess to the service and is a leveller. Healthcare includes the right to termination and this should be across the board and should be made available to all women equally.
Younger and disabled women are less likely to be able to travel freely, and women from some ethnic backgrounds might prefer the discretion afforded by discreet abortions.
The impact differs for individual women. Some will need as visit in person but this is not influenced by any particular protected characteristic.
It places the control in the hands of the female patient, and allows them to take the medication somewhere safe and not have to travel in between pills, potentially bleeding and cramping. This takes out the need to have the money to travel back and forth to the clinic or to rely on someone to come and get you. It also means that it could be a much quicker process as there would not be any need to wait for so many appointments. This would mean unwanted pregnancies could be terminated sooner and the physical effects of pregnancy mitigated for the patient, and less likely to be detected by those around her.
Not sure.
Age - younger women still living with their parents are more likely to lack the financial means to travel to a face to face appointment and to need to conceal their pregnancy from their household. Disability - disabled women are also less likely to be able to travel to a face to face appointment Race & religion - women from minority ethnic or faith related communities are more likely to need care that maximises privacy as they are more likely to face substantial social consequences for seeking an abortion. Accessing services from home means these women do not have to explain an absence from home and are able to best time their call to maintain their privacy Sex - abortions are needed exclusively by female people. Women deserve quality, evidence based care, not care that has been unduly influenced by politicians moralising about the circumstances in which they need the care. Putting barriers in to access evidence based medical care for 1 sex discriminates against women.
-
I think it would be beneficial to many women accessing this service, and particularly to some of the above groups, in relation to travelling, chaperones, and cost.
Improved accessibility of course so positive for disabled people that this should HAVE to be permanent. It's pure discrimination against disabled people by our society and government etc. if disabled people can NOT make choices about their bodies and can't easily access services they need to make those choices. If religious people also find it difficult to make these appointments - as many people may, from any families who might not be supportive of their choices - then of course they also need to be better supported to access choices over their own bodies. This should become a permanent measure for people from any background or community who need it to be.
It would make access easier as long as language translation services etc are available.
Disabled pregnant women will need special care. Those from certain ethnic backgrounds may be denied the help they need because of cultural pressures.
No comment.
An abortion without an in person appointment will increase the potential for harm to women who may be at risk of coercion from the family, a partner or others. Without a mandatory in person appointment it will be difficult to make sure that all women receiving pills are doing so of their own free will, without coercion.
Gellid datrys hynny drwy roi'r dewis i bobl ydyn nhw eisiau cymryd y ddwy bilsen adref neu gyda'r gwasanaethau.
No perceived benefit.
Disabled pregnant women and girls are likely to need special care. As pregnancy may trigger domestic violence, existing abuse can worsen, as abusers know they can cover it up more, if pills may be obtained through the post, so easily. Hospital staff may have objections, either morally or for religious reasons to dealing with the distribution of pills.
It is likely that the impact will again reveal significant inequalities and expose certain communities to greater risk than others. For example those with underlying health conditions, those within abusive relationships where coercive control could have an impact, etc. Those mothers with mental health concerns are also likely to be detrimentally affected by this measure.
The health risks,both physical and mental to those women seeking abortion (as given above Q:3) and to other members of the household(Q:1) plus the risks related to domestic abuse apply equally to those with disability (in fact

some disabilities may increase the physical health risks from DIY abortion). I also suspect that in some ethnic groups women tend to be repressed and may be more likely to request abortion under duress against their will and against their conscience, with no opportunity to confidentially discuss their situation with some-one in a position to help. position to help . Those health workers and possibly others with a conscientious objection to abortion, could feel pressured into doing work connected to abortion provision against their wills and consciences with the fear of losing their jobs.
I have autism and I find it incredibly draining and anxiety filled to travel and to interact with unknown people. I also work full time self employed so I would have to take a financial hit to attend a meeting in person. It's nice to have the option to do everything at home because it would save me a lot of energy, stress and money.
My fear is that this will cause a great deal of mental pressure on young vulnerable women.
If all thanishans were held accountable for any litigation and politicians im sure you wouldn't be so eager there would be no need if people took responsibility for there own actions with free contraception
Many religious people in our society find abortion unconscionable. Making it ""easier"" weighs on our collective conscience. Less consultation leads to further breakdowns in society and among our already fractured communities. I am concerned that there are wider societal concerns that we are brushing away for the sake of what is expedient.
DIY abortions can increase abuse for pregnant women. Similarly, pregnant women who are abused are at greater risk from abortion. Pregnant women are in a high-risk category for domestic abuse, including pressure from their partners to obtain an abortion. The provision of DIY abortion increases the risk of coercion or even being deceived or pressured into taking abortion pills which have been obtained deceptively. The Covid pandemic has seen increased levels of domestic abuse and the provision of telemedicine abortions has only increased the risks and pressures in this area. Religion or belief for healthcare workers who are asked indirectly to be involved with this service, eg. posting pills. Increased use of telemedicine abortion could result in more hospital and clinic staff being asked to indirectly be involved in the provision of abortion services. Many of these staff will have a conscientious objection to abortion due to religious beliefs and this should be taken into account in enabling such staff to opt out of providing any related services.
the best method of saving our young people is to educate them in no sex outside marriage and teach long term committed relationships and proper families. We ae living in a post Christian society but the moral standards of Christianity should be reintroduced and many of these problems would be resolved. Sadly the 'freedom' young people are given is a path to failure and breakdown of decency and moral standards.
Hospital staff who disagree with abortion because they are Christians could be asked to undertake tasks related to the termination, for example, arranging postage of the pills. Nobody should be forced to act against their deeply-held conviction that abortion is the taking of human life. Those who believe abortion is the taking of a human life will want nothing at all to do with it. Protection for conscience must extend to cover this.
Abortions for disability is allowed up to birth! Yet most abortions are 24 weeks.This is discrimination. Christians, catholics and muslims disagree with abortion. They believe abortion is taking life. Therefore it is important that they are not forced to act against their conscience.
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What about the people who work at the hospital who disagree with abortion? Imagine how they feel having to send out these pills
DIY abortions can increase abuse for pregnant women. Similarly, pregnant women who are abused are at greater risk from abortion. Pregnant women are in a high-risk category for domestic abuse, including pressure from their partners to obtain an abortion. The provision of DIY abortion increases the risk of coercion or even being deceived or pressured into taking abortion pills which have been obtained deceptively. The Covid pandemic has seen increased levels of domestic abuse and the provision of telemedicine abortions has only increased the risks and pressures in this area.

Religion or belief for healthcare workers who are asked indirectly to be involved with this service, eg. posting pills. Increased use of telemedicine abortion could result in more hospital and clinic staff being asked to indirectly be involved in the provision of abortion services. Many of these staff will have a conscientious objection to abortion due to religious beliefs and this should be taken into account in enabling such staff to opt out of providing any related services.
Mae ofnau mawr fod yr hyn a gymhellir yn mynd i gael canlyniadau andwyol ar grwpiau fel y rhai a nodir uchod. Beth petai staff ysbyty sydd o gefnir crefyddol arbennig, megis Cristnogion, sy'n anghytuno ag ymgymryd a thasgau cysylltiedig a therfynu beighiogrwydd ac eto'n gorfod postio tabledi? Ni ddylid gorfodi neb i weithredu yn erbyn eu argyhoeddiadau dwfn a diffuant fod erthylu'n fater o gymryd bywyd dynol. Rhaid amddiffyn cydwybod yn y sefyllfaoedd hyn. Caniateir erthylu oherwydd anabledd hyd yn oed at derfyn y beighiogrwydd. Mae hyn yn foesol ac yn wahaniaethol anghywir.
Hospital staff who disagree with abortion because they are Christians could be asked to undertake tasks related to the termination, for example, arranging postage of the pills. Nobody should be forced to act against their deeply-held conviction that abortion is the taking of human life. Those who believe abortion is the taking of a human life will want nothing at all to do with it. Protection for conscience must extend to cover this.
Mae'r Confensiwn Ewropeaidd ar Hawliau Dynol yn diogelu rhyddid y cydwybod, felly rhaid sicrhau ffordd o amddiffyn staff meddygol sydd yn anghytuno ag erthylu ac ni ddylent fod yn rhan o unrhyw gam yn y broses. Hefyd, mae'n rhaid i unrhyw wrthwynebiad cydwybodol allu cynnwys aelodau staff eraill, megis staff gweinyddol a staff rheoli. Yn y rhan fwyaf o achosion ar hyn o bryd, caniateir erthylu hyd at 24 wythnos ond yn achos unrhyw anabledd, mae hawl erthylu hyd at yr enedigaeth, sydd yn arfer hollol wahaniaethol ac anfoesol.
Administrative and managerial staff should benefit from conscientious objection protection. Say that Article 9 of the European Convention on Human Rights protects freedom of conscience. This freedom can only be interfered with where necessary and in accordance with law.
I feel that if there are medical and ancillary staff who have strong religious/humanitarian views on the sanctity of life should not be forced to go against their strongly help beliefs. There should be protection for conscience to cover this; Article 9 of the European Convention of Human Rights protects freedom of conscience. Also the allowance of abortion for babies with disabilities is profoundly discriminatory, as many adults with disability would tell you, and morally wrong. This is only one step away from 'designer babies', something that Hitler tried in Germany in the thirties.
Access to qualified medical advice is vital
Difficult to make an across-the-board judgement on this. For some people with disabilities, not having to attend a clinician appointment will be beneficial. Think it's important you seek feedback from a diverse range of service users about this.
Disabled pregnant women are likely to need special care. Disabled pregnant women may also be more vulnerable to exploitation under the DIY abortion scheme. The following points on the risks for pregnant women would apply equally to disabled pregnant women. • DIY abortions can increase abuse for pregnant women. Pregnancy can be a trigger for domestic abuse, and existing abuse may get worse during pregnancy or after giving birth.13 Abusers who know that women can get abortion pills through the post will be able to cover up their abuse more easily. High levels of abuse have been recorded during the pandemic. • Pregnant women who are abused are at greater risk from abortion. In a study of London clinics, there was a six times higher rate of intimate partner violence (IPV) in women undergoing abortion compared with women receiving antenatal care.14 Women seeking abortion are in a higher risk category for domestic abuse, and victims of abuse are at risk of being forced into abortion. Home abortion both removes the opportunity for detecting abuse via a private consultation in a clinic or hospital, and makes it easier for abusers to force a woman into abortion. Religion or belief • A conscientious objection to abortion could be compromised for hospital staff who become involved in posting out abortion pills to women. For example, staff who are otherwise not involved in abortion could be asked to prepare packages containing abortion pills.
As long as attending a clinical setting was still an option, allowing home use of pills would have no negative inpact on people who felt they needed or wished for any reason to be in a clinical setting. It should always be the individuals choice and the option of terminating at home should not be removed just because it nay not be suitable for certain individuals.
Hospital staff who are Christians could be asked, even expected, to act against their ethical conscience to proceed with termination. All who believe that human life is sacred under any circumstance should not be expected to take a life, and they should be protected in this regard.
DIY abortions can increase abuse for pregnant women. Similarly, pregnant women who are abused are at greater risk from abortion. Pregnant women are in a high-risk category for domestic abuse, including pressure from their partners to obtain an abortion. The provision of DIY abortion increases the risk of coercion or even being deceived or pressured into taking abortion pills which have been obtained deceptively. The Covid pandemic has seen increased levels of domestic abuse and the provision of telemedicine abortions has

only increased the risks and pressures in this area. Religion or belief for healthcare workers who are asked indirectly to be involved with this service, eg. posting pills. Increased use of telemedicine abortion could result in more hospital and clinic staff being asked to indirectly be involved in the provision of abortion services. Many of these staff will have a conscientious objection to abortion due to religious beliefs and this should be taken into account in enabling such staff to opt out of providing any related services.
Hospital staff who disagree with abortion for religious reasons, e.g. Christians, could be asked to undertake tasks related to the termination, for example, arranging postage of the pills. Nobody should be forced to act against their deeply-held conviction that abortion is the taking of human life, and anyone who believes this will not want to be a party to any part of the process. Protection for conscience must extend to cover this.
Pregnant women - the current arrangements have an impact on the physical and mental health of pregnant women Unborn children - The victims of the current arrangements People with disabilities - Increased targeting of babies with disabilities for abortion Medical professionals with religious affiliations - Protection of conscience must extend to them not having to take any part in the provision of pills Administrative staff - These should also be afforded protection from having to take part in the administration of pills if they conscientiously object
This current policy enables domestic abusers to get their way unobstructed. If anything, it will increase domestic abuse across the country. Also: more hands are involved in the provision of this service than would ordinarily be the case. This multiplies conscientious-objection issues with all staff involved. More people will feel compelled to act against their conscience or religious principles than before (thus creating Human Rights issues, and possibly more lawsuits).
There is still a stigma attached to termination and therefore for many people they feel better at not having to sit in a busy clinic. Patients who are older appear to appreciate it more. People with physical disabilities it allows them to access the treatment needed locally without having to travel great distances. If there are queries around capacity of a patient then they would be brought to clinic if we couldn't establish this over the phone. Some patients from different cultures and religions have varied as some have found being able to stay at home with family as very supportive and more comfortable.
Many individuals with deeply religious beliefs (of most faiths) hold that abortion is the taking of a human life and will want no involvement including tasks such as posting pills. These individuals will need strong legal protections to ensure they are not forced into acting against their deeply held convictions or disciplined because of their religious beliefs. Whilst the gestational age limit for most abortions is 24 weeks, abortions for disability are allowed up to birth. This is clearly discriminatory against those with disabilities. It must be a cause of distress for anyone with a disability to know they are considered of less value than those who are healthy.
This is disastrous. So many moral implications. It devalues the sanctity of life in the same way we now have easy divorce and therefore higher divorce rates.It can only lead to an increase in abortion and loss of human life.
I think making the current service provisions permanent would greatly improve the health impact on women and communities. It would allows women to complete the termination from the safety of their own home whilst also allowing groups to attend the hospital should they require the further support. If made permanent, consideration has to be undertaken for service users who will require language line/translation for e-consults or telephone appointments. Also considering communities without access to the internet, phone or laptop to complete the e-consult or telephone contact. For this reason I believe the temporary measures should be offered as permanent but not exhaustive to only telephone or e-consult appointments. This would allow vulnerable groups to still access the services.
The possibility of making this ""temporary"" arrangement permanent is likely to have a baneful effect on people of ALL ethnic and religious backgrounds. In any case the rightness of permitting DIY termination of pregnancy is a moral as well as a practical issue in which the primary consideration is not an individual's ethnic or religious background. As for those with a disability, they are happily often found to have a higher regard for life and to want to take a far more careful view of any suggestion of termination than their able-bodied counterparts.
Disabled pregnant women would be at greater risk of being coerced into abortion and of complications from abortion. Healthcare workers with an ethical or religious objection to abortion may be pushed into involvement with it (by preparing packages containing abortion pills, for example) unless their conscientious objection rights are considerably strengthened.
The possibility of making this temporary measure permanent gives great cause for concern. It is wholly unnecessary. Women with learning disabilities may not fully understand the full implications of taking these pills after a telemedical consultation with a medical professional. They may also be less able to explore how their disability may affect decisions about their pregnancy.
I think making DIY abortion is extremely unwise due to the abuse it has already provided as shown by Christian Concern's secret shopper investigation.

Mental health is of the utmost importance here.
Younger women are disproportionately likely to lack the ability to travel for care. During the pandemic there were also many student-age women living at home with parents and seeking to conceal their pregnancy and abortion. Telemedical care increased accessibility for this group. Women with both physical disabilities and certain mental health issues may struggle to access in person medical care, particularly where they don't have their their own means of transport or require an escort to attend a clinic. Some women may be unable to travel at all. Without telemedicine there is a real risk that these women are forced to turn to illegal online options because they cannot access care within the the formal healthcare Women for which their cultural or religious background disagrees with abortion access are likely to need to access care privately and without the need to travel which is available via telemedicine
By making it easier to keep abortions secret from those in their communities it limits the amount of support that can be given at all stages of the process
very adverse impact on all these groupsunfair advantage to some groups - so it nmust stopbad for everyone
What about those staff who would not normally be involved in abortions but are dragged in now (in various aspects of providing the service in admin, packaging etc.)? If they have conscientious objections to abortion, how is this going to be handled? Home abortions can increase the risk of domestic abuse.
Those who are most vulnerable will be forced to have abortions by others without any chance to confide in anyone in the medical services that they don't want it.
Pregnant women are a high risk category in domestic abuse. The Covid pandemic has increase the amount of domestic abuse. People of religious faith should not be asked to participate in abortion telemedicine.
Christians who believe in the sanctity of life should not be forced to act against their conscience. Abortions are allowed in most case up to 24 weeks but in the case of a disability it can be up to full term which is totally discriminatory and morally wrong
Hospital workers who disagree with abortion for religious or other reasons could be forced to take part in the process - by having to post drugs etc. There would need to be conscientious objection provision, which may cause complications in the workplace. Disabled people who for some reason could not administer the drugs, or people from different ethnic backgrounds with poor language skills would be at a disadvantage to their able-bodied British white peers.
Hospital staff with strong religious convictions and not involved in abortion could find themselves in a difficult situation if asked to participate in some way in the procedure, e.g. by preparing abortion pills to be posted.
I am concerned about the vulnerability of pregnant women. Pregnant women are already a high-risk category for domestic abuse, particularly if disabled, and during the last year's covid-19 pandemic, domestic abuse is increasing. I am concerned that home abortions increase the risk of these women being coerced to get an abortion against their will.
Making the use of home abortion pills permanent will have a negative effect on women who come from cultures where women are traditionally less free than in the West. Many such women are already trapped in the home with limited opportunities to go out or have contact with strangers, even just to speak English, or to see for themselves that the outside world in Britain is not a threat to them. It will have a negative effect on women who don't speak English confidently, and can therefore be more easily manipulated into taking the pills without knowing the consequences. It will have a negative effect on abuse victims of all ethnicities and backgrounds. It will have a negative effect on many disabled women whose health is such that a clinical assessment is particularly important for them.
I cannot answer this difficult question.
DIY abortions can increase abuse for pregnant women. Similarly, pregnant women who are abused are at greater risk from abortion. Pregnant women are in a high-risk category for domestic abuse, including pressure from their partners to obtain an abortion. The provision of DIY abortion increases the risk of coercion or even being deceived or pressured into taking abortion pills which have been obtained deceptively. The Covid pandemic has seen increased levels of domestic abuse and the provision of telemedicine abortions has only increased the risks and pressures in this area. Religion or belief for healthcare workers who are asked indirectly to be involved with this service, eg. posting pills. Increased use of telemedicine abortion could result in more hospital and clinic staff being asked to indirectly be involved in the provision of abortion services. Many of these staff will have a conscientious objection to abortion due to religious beliefs and this should be taken into account in enabling such staff to opt out of providing any related services.
The use of DIY abortions can lead to an increase in the abuse of pregnant women. It is well known that pregnant women are in a high-risk category for domestic abuse and this often comes in terms of pressure from their partners to obtain an abortion. The use of DIY abortion can facilitate abusers obtaining pills through 1/3 party and then pressurising or deceiving a pregnant woman into taking them.
There could be times when people, for example hospital staff, who disagree with abortion on religious grounds could be forced to post out the drugs. All staff including office staff etc should be protected by Article 9 of the European Convention on Human Rights freedom of conscience.
I imagine there are some complex issues on this question which I do not have the knowledge to comment on.

Many people object to abortion on religious or ethical grounds, and they should not be obliged to take any part in this process - for example sending out pills. In general, EMAH implies that pregnancy and abortion are not the weighty matters which in reality they are.
Age . Young women and girls are less likely to have access to means of private travel or the finance for public transport to access in-person services; so to remove the regulatory changes that allow remote access would have a negative and disproportionate effect on this age group. Disability . Previous research has shown that women with disabilities face unique challenges in seeking reproductive healthcare, including issues with access to health facilities and clinics 13 ; by offering a remote service, telemedicine is likely to ease access to abortion services for women who would otherwise face difficulties in engaging with services that require several visits to a clinic. Race and religion/belief. Members of all communities in the UK access abortion services, even where their cultural or religious background disagrees with abortion access. These women are disproportionately likely to need to access care privately and without the need to travel – which is only ultimately available via telemedicine.
Those from more marginalised backgrounds have benefitted the most from telemedicine as it allows them to access care earlier and more discreetly than before.
• Age – younger women and girls under 18 are disproportionately likely to lack the ability to travel for care as a result of lack of access to private transport, or the money to travel on public transport. During the pandemic there were also sizeable numbers of student-age women living at home with their parents and seeking to conceal their pregnancy and abortion. Telemedical abortion services increase accessibility for this group, and enable them to better preserve their privacy. • Pregnancy or on maternity leave – This consultation should focus on the needs of pregnant women – and their ability to access care without unwarranted and non-evidence based intervention or regulation by the government. • Disability – Women with both physical disabilities and certain mental health issues may struggle to access in-person medical care, particularly where they don't have their own means of transport or require an escort to attend a clinic. Some women may be unable to travel at all. Without telemedicine, there is a real risk that these women are forced to turn to illegal online options because they cannot access care within the formal healthcare system. • Race and Religion/Belief - Members of all communities in the UK access abortion services, even where their cultural or religious background disagrees with abortion access. These women are disproportionately likely to need to access care privately and without the need to travel – which is only ultimately available via telemedicine. • Sex – 1 in 3 women will access abortion care during their life. The legal provisions surrounding the accessibility of care are a fundamental part of women's healthcare and the exercise of women's rights in this country. Abortion should not be subject to unnecessary, politically-driven restrictions which are not in place for other forms of gender-neutral healthcare. Women have the right to access abortion, and should have the right to access high-quality, evidence-based care.
The risk of coercion to take the EMA is hugely increased in the case of disabled women and women of ethnic minorities who do not socialise when there is no support available This is particularly the case in incidences of abuse.
Many ethnic and some faith groups will fight any move towards normalising this practice.
Women who are at risk of domestic abuse could be more easily coerced into abortion by an abuser. Many healthcare workers have a conscientious objection to abortion due to religious beliefs and can be asked indirectly to be involved with this service, such as posting the pills. Conscientious objection should be taken into account in enabling such staff to opt out of providing any related services.
definitely makes abortion more available to disadvantaged groups thus putting them on more of a par with more advantaged groups
As people from BAME backgrounds and those who are disabled are more likely to be poor removing he need to travel with its associated cost (particularly in rural ares) makes this change more likely tobenfi them. I am unsure about the question of religious affiliation but it may be that if the womanand her partner do not share the decision to abort it may be beneficial if thais can be arranged without the woman haviing to attend a clinic.
Possibly positive
I think this approach favours reducing inequalities by promoting access to those who would find it most difficult to attend. Consideration needs to be given to those without smart phones (v small numbers in this age group) and the deaf community
It could make worse domestic abuse, and deception. There may be staff who have a conscientious objection to being involved.
Removing face to face consolations all together will impact on people with impaired hearing or vision will be impacted. Some cultures or religious backgrounds may chose to terminate a pregnancy solely down to the sex of a baby. It is possible from a private blood test to find out the gender of a baby as early as 7 weeks. It is essential that this is discussed face to face with clinicians and through assessment undertaken by the professional if they suspect this is the case.
Similar to previous points, by mailing medication out o home addresses there is no way professionals can guarantee they will be used as claimed. Many women experiencing domestic abuse may be forced to take them; girls who have been sexually abused either within the family or outside the family could be forced to take them; and it could cover up over forms of abuse too such as the abuse of those with disabilities

There is evidence that people of colour are disproportionately affected by abortion. Not only so but people with strong religious views may be discriminated against, simply because they cannot with moral integrity be involved in such work, though they are part of the health services. They have signed up to be involved in life-saving and healing service because they have a hight view of life. This legislation demeans the value of human life and puts such medical personnel in an invidious position. That is a very bad place for any society to be in.
It is important that women who do not have English and/or Welsh as a first language, or who have physical and/or learning needs that necessitate a face to face appointment are still able to do so, to ensure they are not disadvantaged.
DIY abortions can increase abuse for pregnant women. Similarly, pregnant women who are abused are at greater risk from abortion. Pregnant women are in a high-risk category for domestic abuse, including pressure from their partners to obtain an abortion. The provision of DIY abortion increases the risk of coercion or even being deceived or pressured into taking abortion pills which have been obtained deceptively. The Covid pandemic has seen increased levels of domestic abuse and the provision of telemedicine abortions has only increased the risks and pressures in this area. Religion or belief for healthcare workers who are asked indirectly to be involved with this service, eg. posting pills. Increased use of telemedicine abortion could result in more hospital and clinic staff being asked to indirectly be involved in the provision of abortion services. Many of these staff will have a conscientious objection to abortion due to religious beliefs and this should be taken into account in enabling such staff to opt out of providing any related services.
Should people be employed who do not believe in abortions they should have protection for conscience.
I disagree with the home abortions .
DIY abortions can lead to the abuse of pregnant women. Similarly pregnant women who are abused are at greater risk from an abortion. Provision of DIY abortion increases the risk of coercion or being deceived or pressured into taking the abortion pills which have been obtained deceptively. The Covid pandemic has seen increased levels of domestic abuse and the provision of telemedicine abortion has only increased the risks and pressures in n this area. Increased use of telemedicine abortions could result in more hospital and clinical staff being asked to be involved in the provision of abortion services. Many of those staff will have a conscientious objection to abortions due to religious beliefs and this should be taken into account in enabling such staff to opt out of providing any related services.
Protection for people to exercise their consciences, whoever they are, should be given. There are undoubtedly members of hospital staff who disagree with abortions, e.g. those who, like ourselves, are Christians. They may be asked to perform tasks related to the provision of abortions, like the packaging and postage of pills. Such people, who believe that abortion is the taking of a human life, will not want to have any part in it whatsoever.
Nobody, such as Christians, should be forced to act against their conviction that abortion is the taking of human life.
Making this permanent could put people from religious backgrounds into really stressful and difficult situations. For example a Christian or Muslim who believes a that abortion is the taking of life, could be asked to post abortion pills. Protection of conscience must be afforded to those who hold such beliefs. This is in accordance with Article 9 of the European Convention of Human Rights.
Differential, and potentially discriminatory impacts are likely for the following at-risk groups: 1. Women from more deprived communities. Economic deprivation can drive women towards abortion. UK figures indicate that in the most deprived populations 26/1000 women per year experience an abortion, whereas, in the least deprived, the figure is less than half of this. The most deprived population is also the most at risk from domestic abuse, from coercion, and for complications of a failed or incomplete abortion attempt. 2. Women with mental health issues. These women are already over-represented among people with post-abortion problems, whether as a result of abortion or for other reasons being currently an under-investigated area. Under the current temporary measure, the rapidity with which EMA medication is received after the first call to a provider, the lack of a 'cooling off' period, and reduced access to trained counselling are likely to increase the stress associated with termination. This and the possibility of post-termination regrets both increase the likelihood of further or increased mental health problems. 3. Women from minority ethnic groups. These populations are likely to have greater difficulties accessing 'telemedicine', due to language, and possibly technical difficulties, and may also have less support for their decisions in the community. 4. In addition to effects on the 'target population', the potential for adverse effects on healthcare workers should also be noted, both in erosion of 'freedom of conscience'/conscientious objection of those required by their professional responsibilities to participate in processes such as packaging and posting pills, and in being expected to take part in a less safe, and less caring service than formerly.
This policy has the capacity to impact further those who have a moral or religious objection to abortion e.g they could be involved in the administration/posting in the practice of killing an unborn baby which they deem abhorrent and barbaric. They should of course benefit from article 8 and 9 of the human rights act
I believe that we are encouraging women to be secretive, to hide unwanted pregnancies from family and quickly solve the problem however the impact abortion has on a woman's mental health is huge and we storing up bigger mental health issues by having a no contact quick home pill solution
Christians should not be forced to take part in any abortion procedures whatever these may be - even sending out the pills by post is anathema to those who believe in the sanctity of human life. All life is precious - and that includes

those with a disability. Abortions are allowed up to full term on the disabled child - that's murder that is sanctioned by the Law. That's a disgrace.
Those who have a sincere and deeply held belief that life starts at inception could easily be discriminated against for refusing to aid in the administration of these drugs. They would in essence be asked to murder a child, even if it has been de-humanised by calling it a foetus. Those who work in abortion clinics have made the choice to work in that environment and they know what kind of work they will be carrying out. Those in hospitals, health clinics, pharmacies etc work in those fields as they want to preserve life. Pressure could very easily be placed upon those who work in these environments and who strongly disagree with abortions to aid in some way in this practise against their strongly held beliefs. Article 9 of the European Convention on Human Rights protects freedom of conscience.
The protected characteristics we feel are particularly impacted by this measure are pregnancy and religion or belief. Pregnancy • DIY abortions can increase abuse for pregnant women. Pregnancy can be a trigger for domestic abuse, and existing abuse may get worse during pregnancy or after giving birth (https://www.nhs.uk/conditions/pregnancy-and-baby/domestic-abuse-pregnant/) Abusers who know that women can get abortion pills through the post will be able to cover up their abuse more easily. High levels of abuse have been recorded during the pandemic. • Pregnant women who are abused are at greater risk from abortion. In a study of London clinics, there was a six times higher rate of intimate partner violence (IPV) in women undergoing abortion compared with women receiving antenatal care (Wokoma TT et al. (2014) A comparative study of the prevalence of domestic violence in women requesting a termination of pregnancy and those attending an antenatal clinic. BJOG 121:627-633). Women seeking abortion are in a higher risk category for domestic abuse, and victims of abuse are at risk of being forced into abortion. Home abortion both removes the opportunity for detecting abuse via a private consultation in a clinic or hospital, and makes it easier for abusers to force a woman into abortion. Religion or belief • A conscientious objection to abortion could be compromised for hospital staff who become involved in posting out abortion pills to women. For example, staff who are otherwise not involved in abortion could be asked to prepare packages containing abortion pills.
During the Covid pandemic, it is reported that cases of domestic abuse have increased. Pregnant women are in a high risk category in such situations. Providing tele medicine abortions has put these women under greater pressures and risks. In cases where women have to access N.H.S. services, due to complications, hospital staff end up being involved in the abortion process. This could be difficult for some on conscience / religious grounds.
I am a Council employed statutory social worker for adults with a learning disability. It is my view that making the home use of both pills permanent, differentially and disproportionately impacts those with disability. I remain shocked that in our Welsh society and nation abortions for disability are allowed up to birth. This is profoundly discriminatory and morally wrong. I am also concerned that making home use permanent may have a differential impact on BAME groups. Something to consider if whether for some (not in all cases, but potentially in some) of these groups with different views on the role and autonomy of the woman from a cultural perspective, may place such less-empowered women at much greater risk of being coerced into having an abortion against their true underlying wishes.
Christians and others who disagree with abortion could be asked to undertake tasks related to termination, such as arranging postage of pills .Nobody should be forced to act against their deeply held convictions that abortion is the taking of a human life. Those who believe abortion is taken a human life will want nothing to do with it, human rights must come into this. The abortion up to birth for disabilities is morally wrong,what does it say of us as a Country ,that those who do not fit our idea of what is normal, should just be got rid of .how must our disable be feeling to know they are worth nothing.
Abortion is not a trivial option, regardless of whether being approached from a ""pro-life"" or a ""freedom to choose"" perspective. The subject is complex and personal. Nobody should ever be forced to become involved against their beliefs and convictions. The right to object must be protected and enshrined in law.
To no extent whatsoever! Background or disability don't really come into the equation when permanent home use is permitted... that would only encourage more promiscuous activity and pass the buck from those who should be compassionate, to those who wouldn't care , so long as a pill would end a life.....and all the responsibilities that would bring if the child were to be born!
Increasing access to abortion medication through the private means of a telephone or video consultation would have substantial benefit for all women who struggle to get to a clinic for any reason. This includes women who will experience shame and stigma if it becomes known that they have attempted to procure an abortion; women who are disabled and so struggle to access a clinic due to their disability; women who are living within controlling and abusive environments, such as intimate partner violence and abuse, or familial abuse (Romanis, et al, COVID-19 and Reproductive Justice, 2020: https://academic.oup.com/jlb/article/7/1/lsaa027/5838025); Aiken and others, Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain, 2018, https://pubmed.ncbi.nlm.nih.gov/28941978/).
Less stigma, less fear of consequences or being protested at clinics
I disapprove of home use of both pills for all pregnant women
The protected characteristic of religion. Increased use of telemedicine abortions by post could result in more hospital and clinic staff being asked to indirectly be involved in the provision of abortion services, such as by posting pills to patients. Many of these staff will have a

conscientious objection to abortion due to their religious beliefs and this should be taken into account in enabling such staff to opt out of providing any related services.
I think that any increased approachabilitiy of the service will be outweighed by the danges to women. Also with the possibility of pills being accessed and then sold online - even less safe practice may ensue for those who do not wish anyone to know that they have approached abortion services.
Nothing in the whole world is 100% safe/ successful. With the normal safeguarding in place I think benefits will hugely outweigh any putative problems. If these are addressed and thought about beforehand then safeguarding teams can be alerted. You would need to discuss this with the people concerned.
• Age – younger women and girls under 18 are disproportionately likely to lack the ability to travel for care as a result of lack of access to private transport, or the money to travel on public transport. During the pandemic there were also sizeable numbers of student-age women living at home with their parents and seeking to conceal their pregnancy and abortion. Telemedical abortion services increase accessibility for this group, and enable them to better preserve their privacy. • Pregnancy or on maternity leave – This consultation should focus on the needs of pregnant women – and their ability to access care without unwarranted and non-evidence based intervention or regulation by the government. • Disability – Women with both physical disabilities and certain mental health issues may struggle to access in-person medical care, particularly where they don't have their own means of transport or require an escort to attend a clinic. Some women may be unable to travel at all. Without telemedicine, there is a real risk that these women are forced to turn to illegal online options because they cannot access care within the formal healthcare system. • Race and Religion/Belief - Members of all communities in the UK access abortion services, even where their cultural or religious background disagrees with abortion access. These women are disproportionately likely to need to access care privately and without the need to travel – which is only ultimately available via telemedicine. • Sex – 1 in 3 women will access abortion care during their life. The legal provisions surrounding the accessibility of care are a fundamental part of women's healthcare and the exercise of women's rights in this country. Abortion should not be subject to unnecessary, politically-driven restrictions which are not in place for other forms of gender-neutral healthcare. Women have the right to access abortion, and should have the right to access high-quality, evidence-based care.
Hospital doctors and nurses who disagree with abortion because they are Christians could be asked to perform tasks such as arranging the sending of abortion pills. Nobody should be forced to act against their conviction that abortion is the taking of a human life. Protection for conscience needs to be extended to cover this situation. The abortion limit for most abortions is 24 weeks but in the case of disability it is allowed up to birth. This is discrimination and morally wrong.
Improve access for those who may have difficulty accessing services- because of patient costs (eg travel costs)- which improves access for young, disabled, ethnic groups and those living in poverty
People with a disability already have problems accessing sexual health services, so no to that group. I don't imagine that anyone is going to impose this type of termination on any group; people from various ethnic or religious groups are perfectly able to make their own choices.
Women in abusive relationships are likely to suffer more under A home abortion service. Getting pregnancy itself can lead to an escalation of domestic abuse, and existing abuse may get worse during pregnancy or after giving birth. Abusive partners, knowing that abortion pills can be got through the post will be able to hide their abuse. The high levels of abuse recorded during the pandemic show the sort of pressure some women come under when they are unable to access face-to-face services. Pregnant women who are in abusive relationships are six times more likely to have an abortion than women getting antenatal care. Home abortions make it harder for professionals to detect abuse. Home abortions make it easier for abusers to force a woman to have an abortion. Hospital or similar staff who have a religious or other belief that abortion is wrong could have their belief compromised when carrying out their day to day duties where these involved to preparation or dispatching of abortion pills. Such staff would not previously had had any part in delivering abortion services.
Permanent home use of both pills could be further isolating for people with disabilities and again put them outside the opportunity for a clinician to assess the situation. Also for people from different ethnic group where language might be a problem. Do they understand exactly what is going on or is someone else putting them under pressure. A physical consultation would ensure that they are not being coerced.
Cost and ease of travel can be a barrier to pregnant girls, disabled women and those with mental health problems. Where the woman's culture or religion is anti-abortion, telemedicine may be their only way to access help.
Women should be given full information about the risks of abortion carried out at any gestation and under any circumstances. Women over ten weeks pregnant should be offered counselling so that they have the opportunity to think about keeping the baby and avoid an abortion which they could regret for the rest of their lives. Particular risks of taking these pills over ten weeks: Less effective later and more harmful for the woman. 50% of women taking pills beyond ten weeks needed surgical intervention. Pain for baby older than ten weeks. When women are told this, many change their minds. At ten-and-a half weeks baby is fully formed and the woman will likely recognise the baby when it is passed.

Women need to be told more about how things change between nine and ten weeks. Up to nine weeks 3% needed surgical treatment to complete the abortion, but one week later it was up to 7%. In asking this question the government is acknowledging that some women will be beyond ten weeks, so this is illegal.
It would prolong the misery of women in domestic abuse situations. These women are especially vulnerable to abuse when pregnant, and in being forced into having unwanted abortions.
Whilst I support home use, I feel medical support must still be available for everyone, should they wish to use it.
Medical staff who are Christians could be forced to act against their religious right of belief.
I would be concerned about bullying & coercion for women who may have greater dependency on male partners & family members who may be abusing, manipulating or coercing them. Women with disabilities are more likely to be at risk of domestic abuse.
By 'people' do you mean women? Why has this terminology changed when it is a biological certainty that girls and women are the ones to request and take up Abortion Care. What does this have to do with communities? Age – younger women and girls under 18 are disproportionately likely to lack the ability to travel for care as a result of lack of access to private transport, or the money to travel on public transport. During the pandemic there were also sizeable numbers of student-age women living at home with their parents and seeking to conceal their pregnancy and abortion. Telemedical abortion services increase accessibility for this group, and enable them to better preserve their privacy. • Pregnancy or on maternity leave – This consultation should focus on the needs of pregnant women – and their ability to access care without unwarranted and nonevidence based intervention or regulation by the government. • Disability – Women with both physical disabilities and certain mental health issues may struggle to access in-person medical care, particularly where they don't have their own means of transport or require an escort to attend a clinic. Some women may be unable to travel at all. Without telemedicine, there is a real risk that these women are forced to turn to illegal online options because they cannot access care within the formal healthcare system Race and Religion/Belief - Members of all communities in the UK access abortion services, even where their cultural or religious background disagrees with abortion access. These women are disproportionately likely to need to access care privately and without the need to travel – which is only ultimately available via telemedicine. • Sex – 1 in 3 women will access abortion care during their life. The legal provisions surrounding the accessibility of care are a fundamental part of women's healthcare and the exercise of women's rights in this country. Abortion should not be subject to unnecessary, politically-driven restrictions which are not in place for other forms of gender-neutral healthcare. Women have the right to access abortion, and should have the right to access high-quality, evidence-based care.
To do so can only promote a careless attitude to abortion, and to wider society. It could also undermine the religious beliefs of those whose knowledge of their religion is not strong.
It would be of particular benefit to those who for reasons of disability, finance, living remotely from a clinic, having work or caring responsibilities, would have difficulty in accessing a clinic. It would be likely to benefit those who have religious pressures, as their attendance at a clinic is more difficult to keep private than a phone or video call.
Continued use of telemedicine would have a positive benefit to everyone but particularly so those with protected characteristic, for many reasons. For example a women in a headscarf or a trans man many find it uncomfortable to sit in a packed waiting room or walk into an abortion service and fear being judged. Those with protected characteristics are unfortunately statistically likely to be poorer, or be subject to abuse, and as above telemedicine means the service is more accessible for them. Furthermore, for those with disabilties a service that you can access from your home is clearly going to make things easier for them to access care.
None
1. COVID 19 has seen an increased level of domestic abuse and women may be pressured into taking abortion pills and/or obtain them deceptively. 2. Healthcare workers may have conscientious objection to abortion due to religious beliefs and should be entitled to opt out of providing any related services.
This is again a ""closed"" question. It should read: ""Do you consider making permanent home use of both pills could have a differential impact on groups of people or communities?If so, give details."" To answer, I believe that the health professionals would treat every woman as an individual case.
Disabled people would be at greater risk if this were to happen. They are generally more vulnerable and require medical assistance throughout pregnancy. Disabled women are also very vulnerable to sexual abuse. DIY abortions can increase the abuse of pregnant women and provide a 'cover' to prevent the abuser from being 'found out'. Women who are abused by a partner are six times more likely to seek abortion than than those who continue their pregnancies - according to a London clinic. Any health workers who conscientiously object to abortion could be made to take part in the preparation and sending out of DIY abortion pills.

This provision would perpetuate cycle of abuse (ex. domestic sexual abuse), exploitation, negatively affect vulnerable and disabled women who would lose a level of protection when attending face-to-face consultation with a healthcare professional. Abusers might feel free to do as they wish due to the possible lack of any consequences for their actions. This process also allows for “unwitnessed” and unregulated abortions, for example taking the tablets incorrectly or beyond the gestational limit. For some cultures, becoming pregnant might be a taboo in certain circumstances, and the easy access to EMA tablets might prevent these women from accessing other options, and access culturally-appropriate help they need, perpetuating fear, guilt and loneliness. Same might occur for disabled women. Full understanding of all the risks might also be difficult to assess via a telephone consultation. Without direct contact with healthcare professional, some people might not realise the seriousness of their actions and/or their short- and long- term consequences. Coercion cannot be fully excluded by a telephone phone call. Women might be denied discussion on the risks and other options for them. In addition, staff who would normally “conscientiously object” to participate in abortions might be required to take part in the process of organising or sending the pills.
The most important argument here is to emphasise that as 1 in 3 women access abortion care during their life this is fundamentally an issue of equality in womens’ healthcare. Certainly the younger cohort of patients without the financial means to travel would be affected disproportionately if made to attend a clinical setting. This will also be the case for women in the immediate postnatal period where currently access to contraception services is still poor. This may inevitably lead to an increase in pregnancy risk, and neonatal complications which its implications on ongoing health resources. The anonymity provided by telemedicine also acts as a shield of defence to those concerned about religious discrimination within their local community and this may also be directly related to their ethnicity.
Religious people, of all faiths, working in hospitals may be forced into parcelling up drugs used to end life of another human being. Even people of no faith, such as atheists and humanists, hold objections to abortion and see the sanctity of life as something to treasure. To force people to participate in a practice they have conscientious objections to would cause distress and anguish. Disabled women, especially if wheelchair bound, would have tremendous difficulties coping with abortion at home/any place, they may be more vulnerable to abuse by intimate partners and less able to gain help.
For people with a disability the removal of a need to travel to a clinic is an advantage. For people from religious or cultural communities where abortion is not allowed, there is risk in being seen at a clinic, and that risk is removed.
DIY abortions can increase abuse for pregnant women. Similarly, pregnant women who are abused are at greater risk from abortion. Pregnant women are in a high-risk category for domestic abuse, including pressure from their partners to obtain an abortion. The provision of DIY abortion increases the risk of coercion or even being deceived or pressured into taking abortion pills which have been obtained deceptively. The Covid pandemic has seen increased levels of domestic abuse and the provision of telemedicine abortions has only increased the risks and pressures in this area. Religion or belief for healthcare workers who are asked indirectly to be involved with this service, eg. posting pills. Increased use of telemedicine abortion could result in more hospital and clinic staff being asked to indirectly be involved in the provision of abortion services. Many of these staff will have a conscientious objection to abortion due to religious beliefs and this should be taken into account in enabling such staff to opt out of providing any related services.
People with ‘disability or on people from different ethnic or religious backgrounds’ are less likely to comply with written instructions; professional advice is more useful.
It could well as in other areas conflict with those of faith who would be required to be part of a pracitice with which they profoundly disagree.
I consider that this will be used most by younger and more vulnerable women.
For those who would be required to be involved in this and any tasks relating to abortion that hold beliefs because of religious or ethic backgrounds should be given protection of their conscience and have the choice not to be involved according to article 9 of the European convention of human rights .
Age. Young women and girls are less likely to have access to means of private travel or the finance for public transport to access in-person services; so to remove the regulatory changes that allow remote access would have a negative and disproportionate effect on this age group. Disability. Previous research has shown that women with disabilities face unique challenges in seeking reproductive healthcare, including issues with access to health facilities and clinics; by offering a remote service, telemedicine is likely to ease access to abortion services for women who would otherwise face difficulties in engaging with services that require several visits to a clinic. Race and religion/belief. Members of all communities in the UK access abortion services, even where their cultural or religious background disagrees with abortion access. These women are disproportionately likely to need to access care privately and without the need to travel – which is only ultimately available via telemedicine.
Age: younger women less likely to be able to access private transport, removing remote consultations disadvantages them Disability: again using remote consultations improves access to those with disabilities Race/religious belief: they may need private access because of the people they live with/their communities - they deserve kindness and privacy afforded by telemedicine
Staff who will be involved in the posting of such pills may not be aware of the nature of the pills and therefore, may unwittingly partake in an action that goes against their conscience. Article 9 of the European Convention on Human

Rights protects freedom of conscience, this freedom can only be interfered with where necessary and in accordance with law.
Age. Young women and girls are less likely to have access to means of private travel or the finance for public transport to access in-person services; so to remove the regulatory changes that allow remote access would have a negative and disproportionate effect on this age group. Disability. Previous research has shown that women with disabilities face unique challenges in seeking reproductive healthcare, including issues with access to health facilities and clinics; offering a remote service, telemedicine is likely to ease access to abortion services for women who would otherwise face difficulties in engaging with services that require several visits to a clinic. Race and religion/belief. Members of all communities in the UK access abortion services, even where their cultural or religious background disagrees with abortion access. These women are disproportionately likely to need to access care privately and without the need to travel – which is only ultimately available via telemedicine
Mae telefeddygyniaeth yn gwneud pethau lot yn haws i ferched ifanc gan eu bod nhw'n llai tebygol o gael mynediad at drafnidiaeth eu hun i fynd i apwyntiad (ac efallai ddim gyda chaniatad eu rhieni i wneud hynny) Mae hefyd yn lot haws i ferched gydag anableddau sydd methu teithio'n hawdd. O bersbectif rhyw/rhywedd, mae'r drefn hon yn lot gwell ar gyfer merched. Mae erthyliad yn ofal iechyd hanfodol bydd 1 ymhob 3 o ferched yn defnyddio ar ryw bwynt, a dylai fod ar gael yn y ffordd fwyaf hygyrch posib. Ni ddylid cyfyngu ar y gwasanaeth hwn am resymau gwleidyddol
Making home abortion a permanent measure would have a disproportionate effect on women living in deprived circumstances, because they are more likely to encounter abuse and exploitation, and are more likely to suffer coercion to undergo an abortion. In some cases, the same is true of women with disabilities.
It would be a massive benefit to me as a disabled woman - it would be so much more accessible
Home abortion makes it easier for to be abused into having an abortion against her will, clinic / hospital consultation makes it harder for the abuser. Hospital staff who have a conscientious objection to abortion pills may find themselves being asked to post pills to women.
The impact of allowing medical abortions to take place at home on a permanent basis without face to face consultations is likely to be felt across all community groups. There may be an added risk to some women from some ethnic or religious backgrounds where pregnancy outside of marriage may be stigmatised or considered disgraceful and where pressure may be placed on young women to undergo abortions against their will or consent. As outlined above, it is not difficult for others to obtain the abortion-inducing drugs by post following a telephone conversation and to administer them forcefully or secretly to a pregnant woman without her consent in order to induce abortion. The potential risk to minors and victims of sexual abuse has been highlighted in the answers above and this risk will be heightened by making the temporary measure permanent. Lessons need to be learned from The Independent Inquiry into Child Sexual Exploitation in Rotherham and other similarly chilling reports. The Rotherham Inquiry report states that many of the victims of sexual abuse became pregnant as a result of the abuse they suffered and many underwent abortions. Opportunities were missed on many occasions to identify these victims of exploitation when they underwent abortion procedures. The absence of face to face consultations makes it much easier for perpetrators of sexual exploitation to continue the abuse of children and others when unintended pregnancies occur and abortions are induced. Members of poorer communities and some minority ethnic backgrounds are much more likely to suffer from this form of abuse and from the lack of adequate medical involvement.
I consider those impacts to be very similar to what I have stated above. Although disabled persons could be in an increased state of vulnerability, which could have devastating effects.
From speaking to countless people who have had an abortion experience, we strongly believe permanent home use of both abortion pills could have an extremely negative impact on various groups of people from different communities: • Disabled pregnant women are likely to need special care. Disabled pregnant women may also be more vulnerable to exploitation under the home abortion abortion scheme. The following points on the risks for pregnant women would apply equally to disabled pregnant women. •Home abortions can increase abuse for pregnant women. Pregnancy can be a trigger for domestic abuse, and existing abuse may get worse during pregnancy or after giving birth.13 Abusers who know that women can get abortion pills through the post will be able to cover up their abuse more easily. High levels of abuse have been recorded during the pandemic. • Pregnant women who are abused are at greater risk from abortion. In a study of London clinics, there was a six times higher rate of intimate partner violence (IPV) in women undergoing abortion compared with women receiving antenatal care. Women seeking abortion are in a higher risk category for domestic abuse, and victims of abuse are at risk of being forced into abortion. Home abortion both removes the opportunity for detecting abuse via a private consultation in a clinic or hospital, and makes it easier for abusers to force a woman into abortion.
There must be protection of conscience for staff whose religious convictions forbid the taking of human life, including the unborn and this would have to be extended to administrative staff. There is huge discrimination against the disabled in allowing termination beyond the statutory 24 weeks for disability.

I also particularly worry about the impact on women in communities where they are not given the freedoms that most of take for granted (or have done until recently!) These must be at greater risk of coercion and having to deal with complications alone.
We know that some groups of women are disproportionately likely to encounter difficulties when required to access in-person care. These include for example: women with childcare responsibilities, women experiencing domestic abuse, survivors of sexual assault, teenage women and girls, women from deprived areas, disabled women, homeless women, women with mental health or substance use issues, LGBTIQA+ women, trans women, women from ethnically diverse backgrounds, women from remote and rural areas, and women with insecure immigration status. Service users in these groups find it difficult to travel to access care because, for example, their movements are monitored by a violent family member, because their disability makes traveling to or attending appointments difficult, because they simply cannot afford to take time off work or pay for childcare, or because they fear or lack trust in healthcare professionals due to negative experiences in the past. Many women are also fearful of interactions with anti-abortion protesters which can be traumatic. In particular, women from conservative backgrounds may be fearful that protesters will reveal their identity and choice to family members. Services must be planned appropriately around these groups. The Public Sector Equality Duty (Equality Act 2010) applies to public sector authorities, including the NSH and local authorities who have a role in planning health services, and requires these organisations to eliminate unlawful discrimination, advance equality of opportunity between different groups and foster good relations. Organisations must ensure that where discrimination against a group is identified appropriate mitigation should be put in place. Often, women in these groups will turn to illegal unregulated online providers of abortifacients like Women on the Web (WotW). This was demonstrated by a 2017 study in which researchers contacted 519 women from England, Scotland, and Wales who had contacted WotW seeking abortion medication. One hundred and eighty women responded, reporting 209 reasons for seeking abortion outside the formal healthcare setting. Among all reasons, 49% were access barriers, including long waiting times, distance to clinic, work or childcare commitments, lack of eligibility for free NHS services, and prior negative experiences of abortion care; 30% were privacy concerns, including lack of confidentiality of services, perceived or experienced stigma, and preferring the privacy and comfort of using pills at home; and 18% were controlling circumstances, including partner violence and partner/family control. (https://www.contraceptionjournal.org/article/S0010-7824(17)30435-3/pdf) However, a recently published study suggests the EMA at home model has increased accessibility for women, including vulnerable groups, who previously might have relied on unregulated online providers of abortifacients for the reasons outlined above. This study compared the number of requests to the online telemedicine service WotW in eight European countries before and after they implemented lockdown measures to slow COVID-19 transmission. The study found that in five European countries where abortion services are mainly provided in hospitals or where no abortion services were available, requests to Women on the Web increased (between 28% and 139%). Whereas in Britain, following the introduction of the EMA at home model, there was an 88% decrease in requests. The implication is that those previously too vulnerable to attend in-person were able to access care through the EMA at home model. (https://srh.bmj.com/content/early/2021/01/11/bmjsrh-2020-200880.full.pdf) Combined, these studies indicate that continuing the EMA at home model would facilitate access to safe, regulated abortion care for all women, but in particular vulnerable groups of women, who previously might have sought unregulated online providers of abortifacients. As such, we consider the use of the EMA at home model to have a positive impact on further access to abortion care services for protected groups. Should the approval order be rescinded, the RCM believes the UK Government has a legal obligation to assess and mitigate the potential impact on these groups.
It will help those who are currently disadvantaged, including those with a disability and those from different ethnic and religious backgrounds. There is clear evidence of need in all these groups, and reducing barriers by continuing telemedicine services is an important step in reducing barriers in these groups. There will be a small proportion of people who still prefer face-to-face consultations, and for these, such services should continue, but for the majority, the telemedicine service is preferable, as shown in surveys quoted above. Younger women will find telemedicine in line with the rest of their life online and may not have the financial means to travel to clinics or be able to take time off work. It will therefore be to their benefit to continue a telemedicine service.
I think this could be monitored closely as part of the provision. I can also see if the temporary measure were continued this could have a positive effect upon access for people with a motor or visual disability for example - and for those whose backgrounds make attending unchaperoned appointments difficult.
Telemedicine can help a wide range of women from different backgrounds who would otherwise struggle to access services
DIY abortions can increase abuse for pregnant women. Similarly, pregnant women who are abused are at greater risk from abortion. Pregnant women are in a high-risk category for domestic abuse, including pressure from their partners to obtain an abortion. The provision of DIY abortion increases the risk of coercion or even being deceived or pressured into taking abortion pills which have been obtained deceptively. The Covid pandemic has seen increased levels of domestic abuse and the provision of telemedicine abortions has only increased the risks and pressures in this area.
It offers women choice. If a woman prefers to take the pill at home with the comfort and privacy that affords, then she may do so. However, we need to recognise that not all women will have these conditions at home and may wish to

keep the procedure private from their families. Women in this position should be offered a choice.
As always, the safety and well being of the patient should be the most important factors.

DIY abortions can increase abuse for pregnant women. Similarly, pregnant women who are abused are at greater risk from abortion.
Pregnant women are in a high-risk category for domestic abuse, including pressure from their partners to obtain an abortion. The provision of DIY abortion increases the risk of coercion or even being deceived or pressured into taking abortion pills which have been obtained deceptively.
The Covid pandemic has seen increased levels of domestic abuse and the provision of telemedicine abortions has only increased the risks and pressures in this area.
Who can also state that the home abortion will not be traumatic, as the women may be in pain and having to deliver a placenta and foetus. At 9 weeks, 6 days the foetus will be recognisable not just cells.

Religion or belief for healthcare workers who are asked indirectly to be involved with this service, eg. posting pills.
Increased use of telemedicine abortion could result in more hospital and clinic staff being asked to indirectly be involved in the provision of abortion services. Many of these staff will have a conscientious objection to abortion due to religious beliefs and this should be taken into account in enabling such staff to opt out of providing any related services.
Coercion to people with disabilities and other groups could continue and communities will continue to bear the impact.

AGE
Younger women and girls under 18 are disproportionately likely to lack the ability to travel for care due to a lack of access to private transport, or the money to travel on public transport. During the pandemic there were also sizeable numbers of student-age women living at home with their parents and seeking to conceal their pregnancy and abortion. Telemedical abortion services increase accessibility for this group and enable them to access care whilst retaining their privacy.

DISABILITY
Disabled women may have different access needs which affect their capacity to visit hospitals and clinics in person or mean that they must forgo privacy in order to attend appointments or access clinic premises. This applies to women with physical disabilities who may struggle to access scans, but also women with disabilities such as agoraphobia which limit their ability to attend healthcare premises.

Disabled women are less likely to have their own means of transport and may require an escort to attend a clinic. Some women may be unable to travel at all. Without telemedicine, there is a real risk that these women are forced to turn to illegal online options because they cannot access care within the formal healthcare system.

RACE AND RELIGION/BELIEF
Members of all communities in the UK access abortion services, even where their cultural or religious background disagrees with abortion access. These women are disproportionately likely to need to access care privately and without the need to travel due to their living or social arrangements – accessing abortion care without the need to travel is only ultimately available via telemedicine.

Further, religious women report that their experience of anti-abortion protesters outside clinics has a negative impact on their mental health and in some instance and caused severe anxiety.

SEX
1 in 3 women will access abortion care during their life. The legal provisions that allow women to access this care are a fundamental part of women's healthcare and the exercise of women's rights in this country. Abortion should not be subject to unnecessary, politically-driven restrictions which are not in place for other forms of gender-neutral healthcare. Women have the right to access abortion, and should have the right to access high-quality, evidence-based care.

There are various groups of people and communities that struggle to access healthcare through traditional routes. Whether based on a disability hindering one's ability to access a clinic, or socioeconomic disadvantage preventing the use of public transport to get there, the reality is that access to abortion care has never been equal. Telemedicine reaches these people where they are, removing the need for them to put themselves at some form of risk to access care.

Those from certain ethnic or religious backgrounds can also benefit. In cultures where getting pregnant in certain circumstances is a source of shame, discretion will be hugely valued by those needing to access care.

Young women, disabled women, and women from communities/religions which disapprove of abortion are all likely to find access to clinic premises more difficult, and for these three groups the possibility of the evacuation of products commencing whilst using public transport must be appalling.

Everyone should be able to access safe, free abortion but with a legal requirement to attend a clinic, that doesn't happen. Disabled women, LGBT people and care-experienced women and girls in Wales may experience difficulties in accessing reproductive health services, and the costs of travel and childcare are barriers to abortion which have a greater impact on women facing multiple deprivations and discrimination.
Telemedicine enables providers to tailor care to individual women and their needs. Some women are disproportionately likely to encounter difficulties in accessing in-person care – including mothers, victim-survivors of sexual violence, women experiencing domestic abuse, teenage women and girls, women from deprived areas,

LGBTI people, disabled women, BAME and migrant women, homeless women, women with mental health or substance use issues, and women with insecure immigration status. Particularly: • Race/ethnicity and religion – Women from certain religious or cultural backgrounds may experience greater difficulties in accessing in-person care as a result of their living or social arrangements. Travelling a greater distance to a standalone hospital or clinic may be impractical or impossible if they are unable to attend healthcare appointments alone. Further, we have received reports from religious women that their experience of anti-abortion protesters outside clinics has a negative impact on their mental health and in some instance and caused severe anxiety. • Age – younger women and girls may find it more difficult to travel to in-person appointments to lack of access to private transport, the cost of public transport, and education or work commitments. • Disability – Disabled women may have different access needs which affect their capacity to visit hospitals and clinics in person or mean that they must forgo privacy in order to have support to attend or access premises. This applies to women with physical disabilities who may also struggle to access scans, but also women with disabilities such as agoraphobia which limit their ability to attend healthcare premises. • Pregnancy and maternity – Women who are already mothers account for more than half of all abortions across the UK. Requiring all women to attend clinics for lengthy appointments often means that childcare has to be found, and either privacy compromised, or money found to pay for professionals. This concern is particularly acute where women are caring for a child with special needs where respite care is unavailable.
This is outside our remit, but suspect that it will increase equality of access.
Religion or belief for healthcare workers who are asked indirectly to be involved with this service, eg. posting pills. Increased use of telemedicine abortion could result in more hospital and clinic staff being asked to indirectly be involved in the provision of abortion services. Many of these staff will have a conscientious objection to abortion due to religious beliefs and this should be taken into account in enabling such staff to opt out of providing any related services.
Anyone who would find it difficult to travel themselves without help from a family member would benefit from not having to attend. This may include women with disabilities, women with partners who control or abuse them or women who don't drive. Women from ethnic minorities may fall disproportionately fall into these groups.
so many different disabilities- if it is mobility or for some one in remote community, it will improve access. Also women who find themselves with an unwanted pregnancy from controlling community or disapproving faith will be free-er to access as more private
The significant barriers that are faced by many in accessing abortion clinics disproportionately impact on those who might be structurally disadvantaged for a variety of reasons. Access is often very difficult for those who are unable to easily leave the home, or to travel long distances (where necessary) to a clinic as a result of disability. Equally, access can be difficult for younger women (who often have less resources that enable them to travel). Making home use permanent will enable this people much easier access to care because they will not have to travel long distances, arrange childcare, or figure out how to manage the distance in terms of their physical or financial circumstances in order to get the abortion they need (Romanis, Parsons, and Hodson, 2020). Abortion care can also be difficult for transgender people (assigned female at birth) to access, and remote care and home use might make it more comfortable for them because of the level of privacy it affords, and the additional comfort of being in their home environment. In a recent study conducted in England, many of the people who reported feeling unable to access clinics (and therefore sought abortion medications unlawfully online) reported doing so because they were worried about the implications of their family finding out. Some of these concerns were related to ‘fear of strong disapproval on religious grounds – leading to shunning or, in extreme circumstances [and] fear of honour killing’ (Aitken and others 2018). This demonstrates that access to clinics could be limited for some people from some religious or other cultural minority backgrounds, and that remote provision might enable them to better access care without the same concerns about being seen going into a clinic and the possible repercussions. There is clear evidence that these people find online means of obtaining the medications for use at home to be a better alternative. References: Romanis, EC, Parsons JA, and Hodson, N. 2020. ‘COVID-19 and Reproductive Justice in Great Britain and the United States: ensuring access to abortion care during a global pandemic.’ Journal of Law and the Biosciences https://academic.oup.com/jlb/article/7/1/lsaa027/5838025 Aiken, A and others. 2018. ‘Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain,’ Contraception 97 (2): 177-183.
even more essential to have a qualified mental health professional with vulnerable client groups
There is an increased risk of coercion and abuse with the use of ""pills through the post"". This could be even greater in those with an additional vulverability.
Allowance should be made for medical personnel who are opposed to abortions to exercise their right of conscience.
Making this permanent will have a profound impact on those asked to participate in the provision of these pills, whether in a medical capacity, administrative capacity, or any other capacity, who as a matter of conscience, religion or culture disagree with abortion and view it as the taking of a human life. Protection for conscience must be extended to cover this in accordance with Article 9 of the European Convention on Human Rights.
Hardly likely unless there are religious grounds [Mormons / Muslim etc] or for reasons similar to those who refuse the Covid Vaccines .

The concept of home abortion is both abhorrent in both a secular and religious context. The potential for both physical and mental abuse of women and girls is only exacerbated by the provision of uncontrolled use of abortion drugs
DIY abortions can increase abuse for pregnant women. Also, pregnant women who are abused are at greater risk from abortion. Making these temporary measures permanent will only embed the greater risks associated with vulnerable or abused women. People from certain ethnic or religious backgrounds who might not normally be involved with the provision of abortion e.g. clerical staff, may well have conscientious objections to being involved with abortion services.
Home use of pills should never be an option for any young girl or woman should ever be a substitute for proper medical care and supervision when pregnant.
Hospital staff from religious background such as Christians who disagree with abortions would not want to take part in any way and could be asked to post pills out. Protection for conscience must be extended to cover this including administrative and ancillary staff. Article 9 of the European convention on human rights protects freedom of conscience.
DIY abortions can increase abuse for pregnant women. Similarly, pregnant women who are abused are at greater risk from abortion. Pregnant women are in a high-risk category for domestic abuse, including pressure from their partners to obtain an abortion. The provision of DIY abortion increases the risk of coercion or even being deceived or pressured into taking abortion pills which have been obtained deceptively. The Covid pandemic has seen increased levels of domestic abuse and the provision of telemedicine abortions has only increased the risks and pressures in this area. Religion or belief for healthcare workers who are asked indirectly to be involved with this service, eg. posting pills. Increased use of telemedicine abortion could result in more hospital and clinic staff being asked to indirectly be involved in the provision of abortion services. Many of these staff will have a conscientious objection to abortion due to religious beliefs and this should be taken into account in enabling such staff to opt out of providing any related services.
People from some religious or ethnical groups object to killing babies through abortion on religious or other ethical grounds. Medical staff in these groups should not have to be involved in any capacity. Some, under pressure to conform, could be lost to the profession completely. Pregnant women from such groups, reluctant to visit a clinic or surgery because of family sanctions, could feel ""pills by post"" would be a better option - and then find that, having taken the pills secretly and alone, they are totally unsupported in any resulting medical emergency.
The right for medical staff to refuse to participate in an abortion on ethical or religious grounds could be taken away. Staff could be made to send out abortion drugs or participate in medical procedures when the abortion has gone wrong. Consciencious objection must not be overuled.
DIY abortions can increase abuse for pregnant women. Pregnant women are already at a higher risk of abuse, and pregnant women who are abused are at greater risk from abortion. The pandemic has seen increased levels of domestic abuse, and the provision of pills by post has only increased the risks and pressures in this area. Healthcare workers who conscientiously object to this service could still be asked to be indirectly involved. This should be taken into account.
Both groups may already face limitations of access and communication. On the whole these will be made worse by the lack of access to personal consultation, as mentioned. There may be a few cases where the impersonal connection is welcomed, but these are the exceptions.
For anyone coming from a religious or ethnic background where unmarried sex (and therefore pregnancy) are viewed as shameful, there are clear risks that they might be coerced into having an unwanted abortion.
Hospital staff who disagree with abortion because of their religious beliefs could be asked to undertake tasks related to the termination, for example, arranging postage of the pills. Nobody should be forced to act against their deeply-held conviction that abortion is the taking of human life. Protection for conscience must extend to cover this. Ancillary, administrative and managerial staff should also benefit from conscientious objection protection. Article 9 of the European Convention on Human Rights protects freedom of conscience which can only be interfered with where necessary and in accordance with law. It should also be noted that in all parts of the UK abortions up to full term are permitted for disabilities such as Down's syndrome. This is profoundly discriminatory against disabled people, as abortions for other reasons are only allowed up to 24 weeks' gestation. If the Welsh Government is genuinely concerned about the impact of abortion on those with protected characteristics, it should seriously consider this discrepancy.
The Royal Colleges report on Induced Abortion and Mental Health Induced_Abortion_Mental_Health_1211.pdf (aomrc.org.uk) found that "The most reliable predictor of post-abortion mental health problems is having a history of mental health problems prior to the abortion" while also mentioning other relevant issues such as "pressure from a partner to have an abortion". Other groups are at particular risk of emotional harm from abortion: for details and references, see Microsoft Word - Reardonmacro2.doc (afterabortion.org). Teenagers are at particular risk as are those who believe their abortion is morally wrong, including those coming from particular religious backgrounds. Any provision which facilitates a speedy and secret recourse to abortion will bear particularly hard on women in this category, many of whom will also be minority ethnic women who are aborting because they lack awareness of State and voluntary resources available to help them have their baby. Issues of consent will also be particularly difficult in the case of remote consultations with women who speak little English or Welsh, and in the case of women who are intellectually disabled.

Pregnant women are in a high-risk category for domestic abuse, including pressure from their partners to obtain an abortion. Access to DIY abortion increases the risk of coercion or being pressured into taking abortion pills which have been obtained deceptively. Many staff will have a conscientious objection to abortion due to religious beliefs. This should be taken into account in enabling such staff to opt out of providing any related services.
These divides are immaterial. All women without professional knowledge will be vulnerable to the holistic possible adverse effects.
• There are greater risks involved in faster and easier access to abortion for some people who have disabilities. In particular women with learning disabilities may not fully understand the full implications of taking these pills after a telemedical consultation with a medical professional. They may also be less able to explore how their disability may affect decisions about their pregnancy. • Some women who do not speak English could struggle to understand information relating to the risks and dangers involved in having home abortions.
There would certainly be a differential impact for pregnant women. From what we have seen from Kevin Duffy's 'Mystery Shopper' study, is that it is clear that the current legislation is incredibly vulnerable to abuse and deception, with the study revealing that telemedicine is massively exposed to coercion, impersonation and abuse. Therefore, with this current legislation, many pregnant women will not be properly safeguarded and are now susceptible to being forced to have an abortion while their abuser would easily be able to cover it up. While a concerning prospect, domestic abuse is unfortunately a reality for many women, with the UK lockdown revealing a drastic increase in domestic abuse, with the Office for National Statistics revealing that "Looking specifically at the period affected by the coronavirus (COVID-19) pandemic, the police recorded 259,324 offences (excluding fraud) flagged as domestic abuse-related in the period March to June 2020. This represents a 7% increase from 242,413 in the same period in 2019 and an 18% increase from 218,968 in 2018" (Stripe, N., 2020. Domestic abuse during the coronavirus (COVID-19) pandemic, England and Wales - Office for National Statistics. [online] Ons.gov.uk. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseduringthecoronaviruscovid19pandemicenglandandwales/november2020> [Accessed 23 February 2021].). Furthermore, pregnant women are particularly vulnerable to be abused further for their pregnancy and subsequently coerced into having an abortion. Kevin Duffy illustrates this, explaining that a study of London clinics found that there was a higher rate of intimate partner violence in women undergoing abortion compared to women receiving anti-natal care. In regards to ethnic and religious backgrounds, there would be a clear differential impact on service providers with religious beliefs. Whilst the BMA state that "Section 4 of the Abortion Act is a conscientious objection clause which permits doctors to refuse to participate in terminations" (Bma.org.uk. 2020. [online] Available at: <https://www.bma.org.uk/media/3307/bma-view-on-the-law-and-ethics-of-abortion-sept-2020.pdf> [Accessed 23 February 2021].), it is unclear exactly what the level of this "participation" is that they are permitted to refuse. For example whether an individual they would be able to opt-out of being required to post the medical abortion pills.
People from 'faith' backgrounds usually consider life to have begun in the womb, at conception, and not from birth so abortion from home will cause much concern.
Home abortion schemes are open to abuse from every section of society but may have more impact on some ethnic or religious groups. The absence of a private consultation is particularly concerning for minority ethnic women who come from cultures where women may be pressured into seeking abortion for specific reasons eg based on the sex of the fetus. There is evidence that women in UK are increasingly coming under pressure to undergo sex-selection abortion. Despite the 24 week limit for most abortions there is exception for those with disability, up to birth. This can only be described as discriminatory and morally wrong. Denying the rights of the unborn child. Section 4 of the Abortion Act 1967 ensures any medical professional can conscientiously object to participating ""in any treatment authorised by this Act"" except that ""which is necessary to save the life or to prevent grave permanent damage to the physical or mental health of a pregnant woman"" It is unclear how this fits into the context of ""DIY"" home abortion.
Let me state that I work with a wide variety of adults with physical and learning disabilities. Therefore, I can say that I know these people as individuals who are interesting to know, in their own personalities. They are loved by their families and cared for by all who know and support them in various aspects of their lives. I find it reprehensible that people I know, whose company I enjoy, might not be alive and here now, because of the inconvenience of a gene deletion or replication. Are you proposing that we dispose of cancer patients, on the basis of their errant genetics? I find this whole matter both distasteful and shameful. It seems that human life is disposable when deemed inconvenient or untimely. And it is a disgrace in our nation that it had become so. I am a committed Christian, but aside from my faith, I believe it is immoral for anyone, even the mother, to decide that a unborn life would be inconvenient, whether because of study or career progression. I also consider that there may well be women having used this facility during lockdown to ""get rid"" of babies without the father even knowing that he could have been a father. I believe that the Human Rights Act states that people have the right to a family life and have children: that extends to the father and the child must be born to begin the family.
I am not sure
As in my answer to Q1, there are many for whom a telephone or video appointment is more convenient, but some will find such methods much harder, such as those with intellectual disability, deafness, those with mental illness, or those who find technology difficult (https://publications.parliament.uk/pa/cm5801/cmselect/cmhealth/320/32009.htm).

Furthermore, for many people with intellectual disability, it could be extremely difficult to confirm over the telephone or by video consultation whether they wish to go through with an abortion, and whehter they have provided informed consent.

Women should be given full information about the risks of abortion carried out at any gestation and under any circumstances, but especially about the risks of taking the pills after 10 weeks.
This question demonstrates the reality known to the government and the Department of Health and Social care that gestational age is a critical determinant of the safety and efficacy of medical abortion, and the fact that some women will not, or will not be able to, provide the correct information to enable the abortion provider to accurately assess gestational age.
Women over ten weeks pregnant should be offered counselling so that they have the opportunity to think about keeping the baby and avoid an abortion which they could regret for the rest of their life.
Religion or belief issues should be considered not only for those seeking abortions, but also for healthcare workers who are asked indirectly to be involved with this service, eg. posting pills.

DIY abortions can increase abuse for pregnant women. Similarly, pregnant women who are abused are at greater risk from abortion.
- Pregnant women are in a high-risk category for domestic abuse, including pressure from their partners to obtain an abortion. The provision of DIY abortion increases the risk of coercion or even being deceived or pressured into taking abortion pills which have been obtained deceptively.
- The Covid pandemic has seen increased levels of domestic abuse and the provision of telemedicine abortions has only increased the risks and pressures in this area.

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If there is coercion or pressure arising from any particular ethnic or religious background, it can only be harder to screen for and to appropriately support the woman or girl if she is not seen in person.

Age. Young women and girls are less likely to have access to means of private travel or the finance for public transport to access in-person services; so to remove the regulatory changes that allow remote access would have a negative and disproportionate effect on this age group.

Disability. Previous research has shown that women with disabilities face unique challenges in seeking reproductive healthcare, including issues with access to health facilities and clinics (1); by offering a remote service, telemedicine is likely to ease access to abortion services for women who would otherwise face difficulties in engaging with services that require several visits to a clinic.

Race and religion/belief. Members of all communities in the UK access abortion services, even where their cultural or religious background disagrees with abortion access. These women are disproportionately likely to need to access care privately and without the need to travel – which is only ultimately available via telemedicine.

(1) Engender (2018) Our Bodies, Our Rights: Identifying and removing barriers to disabled women's reproductive rights in Scotland. Available at < https://www.engender.org.uk/files/our-bodies,-our-rightsidentifying-and-removing-barriers-to-disabled-womens-reproductive-rights-in-scoltand.pdf>

1) In England & Wales, black and ethnic minority women disproportionately undergo abortion (22% of abortions in 2019 yet only 14.1% of women are from an ethnic minority in England according to the 2011 Census) which is an unacceptable disparity and must be immediately addressed by the Welsh and UK Government. If the current temporary measures continue then complete decriminalisation could occur or changes made to medicines regulation meaning racists could sell abortifacient pills in areas with a high proportion of ethnic minority women which is completely unacceptable.

2) Pregnant women would be at much greater risk of abuse if the temporary measures continue as easy access to abortifacient pills without clinic attendance give men power and control over women's pregnancies. Pregnancy is strongly associated with domestic abuse within violent relationships with an EU-wide survey by the European Union's Agency of Fundamental Rights (FRA) finding 42% of women had experienced violence during a pregnancy within a previous violent relationship (https://fra.europa.eu/en/publication/2014/violence-against-women-eu-wide-survey-main-results-report, p.52.) and it recommends "Healthcare professionals need to be aware of the vulnerability of pregnant women to violence so that they are in a position to effectively address this." The World Health Organisation gives evidence of increased risk of femicide for pregnant women stating "Improving detection of severe partner violence within health systems, particularly during pregnancy, has been suggested as a means of reducing the risk of femicide." (https://www.who.int/reproductivehealth/publications/violence/rhr12_38/en/) so that outside the pandemic abusive partners would know they could more easily coerce an abortion against women's wishes and use that knowledge to continue violent behaviour during or after a pregnancy without detection. The FRA survey found only 25% of the most serious incidents of partner violence in the UK came to the attention of the police (page 61) so that the vast majority of abuse is hidden from the Government, as the £47 billion annual costs suggest.

3) If continued, the temporary measure would impact and be destructive to married couples as it is estimated 40-50% of relationships end following abortion (https://www.deveber.org/wp-content/uploads/2017/09/Chap15.pdf, p.218.). Relationship breakdown can lead to financial and emotional hardship for women and increase the likelihood their next or a subsequent partner is abusive with FRA Table 2.1 on page 28 indicating 34% prevalence of women in the UK had experienced physical and/or sexual violence by a previous partner. Official statistics consistently show

married women in England & Wales, in Northern Ireland, and the Republic of Ireland are four times less likely to have an abortion compared to unmarried women (20% versus 80%). The Welsh Government must encourage marriage to tackle this crisis. 4) People who hold a religious belief opposing abortion such as healthcare workers, post office staff, couriers, and possibly even retail workers in future could face discrimination and potentially lose their jobs if they objected to selling, preparing, or delivering abortifacient pills which would be an unacceptable impact.
Young women especially beneift from a telemedicine pathway as they especially value the privacy of remote consultation Black, Asian, and Minority Ethnic (BAME) women and women from religious communities similarly find this easier access to care without travelling to a clinic is discrete and avoids restrictions being imposed by family members on their reproductive choices. Similary those in abusive/controlling relationships subject to reproductive coercion particularly benefit from options of remote access. Without telemedicine, women become desperate and turn to illegal online options. Now that we know - and have evidence that we can support and treat them through formal healthcare system using remote consultation and home use of both medications for abortion we must continue to allow this to protect their reproductive freedoms.

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?

It should not even be discussed,just because a person is from a disadvantaged area or disabled doesnt mean they should be disposed of or treated any differently.
Abortion is not the solution for poverty. There is a risk that abortion pills by post will be promoted as being especially important for women in economically deprived areas around Wales and throughout the rest of Britain. The ease and speed of getting abortion pills will mean that women who are considering abortion for financial reasons have less time to make their decision. Critically, DIY abortion could mean that women do not get the help they need to deal with their circumstances.
Poverty can drive women towards having an abortion but abortion is not a solution to poverty. The ease and speed of obtaining abortion pills will mean that women contemplating an abortion for financial reasons will have less time to deal with their decision. Women in deprived areas have far more abortions than women in wealthier areas - and the use of pills could cover up the fact that poverty is forcing women not to go through with having a child.
Anything which inhibits access to abortion is a good thing, as abortion is a terrible and desperate thing, and should be avoided. Long live the babies of the economically disadvantaged! They will run the nursing homes for the retired rich people and superannuated abortion zealots, without having to send to the Philippines. Good luck, to you, girl, if you live out in the country, and can't get to the doctor! That baby may be the life-changing event that you and your family need to help you out of self-indulgence and selfishness. Long live adoption agencies! Why should they have to send abroad for babies for loving couples to adopt? Inhibiting access to abortion might be about the best thing our society might offer, if we want a society to continue to exist at all. Besides, what evidence is there, with one quarter of babies already being killed before birth, that women (or their insistent boyfriends) have been unable to get an abortion before the advent of do-it-yourself? This kind of mythology is unworthy of a sensible debate.
It is well-known that economic deprivation can drive women to seek abortion -- if they consider that they just can't afford to have another child. The BPAS has actually highlighted this.
Gp`s and Sexual Health clinics are aware that, women can self-refer for abortion care. I do not think this will have any impact.
I think it will have a positive impact and reduce discrimination based on socio-economic status. For people without easy means of travel or those in rural areas it is harder to visit a clinic. Allowing home use reduces barriers to them being allowed to evercise choice
There are clearly benefits on these case in not having to make an additional journey - or indeed an initial journey
This may vary from place to place - it is wise to take local advice. But see above!
i think the impact will be neither postive or negative for this group
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I don't think ease of access is enough to justify or outweigh the risks involved with making this act permanent.
It does not give any advantage.
Poverty can drive abortion against wills and it is not a solution to poverty, more social care needed not procedures for making it easier for the authorities to distance themselves from problems, find so called cheaper and easier methods to solve problems and absolve their consciences
All this would offer is easing the burden on society.. every life is worth living !
Not known but it will certainly put the more disadvantaged in greater risk of infection/death etc for obvious reasons.
Poverty can drive women to abortion. Theres a risk that pills would be promoted to women in more deprived areas. Ease and speed means that women considering financial reasons to abortion have less time to make their decision.
All forms of abortion are very sinful. The thought of sending abortion pills through the post is morally repugnant. Women from disadvantaged backgrounds should receive financial assistance in order for them to give birth to their baby.
I'm sure it will make it easier for people to get an abortion regardless of disadvantage but that doesn't mean it is right.
Medical abortion means more abortion among the poor increasing the mental ill-health that comes with abortion. It also increases the incidences of poorer fathers putting their wives/girlfriends under pressure to abort due to its accessibility. It empowers the fathers who seek to control or oppress.
Statistics from the Department of Health and Social Care reveal that "Women living in more deprived areas are more likely to have abortions than women living in less deprived areas. The rate in the most deprived decile is 26.1 per 1000 women. This is more than double the rate in the least deprived decile of 12.0 per 1000 women." Women who are living in poverty or are economically disadvantaged are already pushed towards abortion by social factors. We should not be encouraging them to see abortion as their only way out of an unexpected or unplanned pregnancy. Rather, we should be seeking to ensure that these women are offered the financial support and help that they need. Removing the obligation for these women to attend a clinic removes opportunities for these women to receive confidential support.
It is important that women living in poverty are given more support by the government. Abortion must not be seen as the solution to tackling poverty or the issuing of DIY abortions by post as the governments way of tackling poverty.

All women, in every geographical area or socio/economic group should have access to provisions that will allow them to have children and deliver them at full term ,in safety and with full social health care provided for the needs to bring up the child.
I feel the DIY abortions would increase the access to people from more economically disadvantaged areas.
Poverty can drive women to seek an abortion. Abortion is not a solution to poverty but the ease and speed of getting abortions pills by post mean that women have less time to consider their options and could mean that the women do not get get the help they need to deal with their circumstances.
I cannot comment on this as I totally disagree it's use .
Obviously the haves would gain and the have- nots lose as in all aspects of life.
Abortion is no cure for poverty, many women are driven to abortion because of poverty, the Dept. of Health and Social Care statistics show that women in the most deprived section of society are more than twice as likely to seek abortions as women in the least deprived section. The answer for a Labour government is to raise them out of poverty, not facilitate easier abortion. The speed with which pills by post allow abortions to take place takes away the time which would otherwise would give a woman adequate time to carefully consider her decision.
easy access to abortion will cause more harm than you think, human life is priceless and we are not in charge to decide whether to have an abortion or not, it's all in hands of God - he gives life and also terminates it whether you believe or not - you must not allow to kill unborn babies in the name of the law!
As terminations are already paid, it is not likely to make much economic difference to the women, it may however be a cheaper service for the provider. This should not be the priority for good care or service.
Poverty can drive women towards abortion. Statistics from the Department of Health and Social Care reveal that "Women living in more deprived areas are more likely to have abortions than women living in less deprived areas. • Abortion is not a solution for poverty. There is a risk that abortion pills by post will be promoted as being especially important for women in deprived areas. The ease and speed of getting abortion pills will mean that women who are considering abortion for financial reasons have less time to make their decision. Critically, DIY abortion could mean that women do not get the help they need to deal with their circumstances.
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As above people doing it without proper council and being forced into something.
Allowing telephone access and reducing the necessity to travel would increase geographical equity.
I do not see how this would make any difference. Every area has access to GPs and other medical practitioners.
We need to remember that we are not talking here about prescribing of medication for a chronic condition that can easily be arranged remotely. We are talking about pregnancy termination which to many woman is emotionally difficult. I can not understand how it's still mandatory to attend in person one to one appointment before anti-conception pills are prescribed for the first time and it's not mandatory to attend in person one to one appointment when pregnancy termination pills are prescribed. This is illogical. Potentially home use of EMA pills would increase access - which is not good because at the same time it would increase risks associated with inappropriate use of those pills.
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I think it would increase the access to abortion for people in all areas.
Increase, as it removes the need to take time from the working day for a second appointment
Abortion rates in deprived areas are already significantly above those in less deprived areas - increasing the 'ease' of the process of abortion in these circumstances risks exacerbating this unjust inequality further, replacing the effective tackling of poverty needed to help those struggling financially with a pregnancy, with cheap 'abortion by post'.
It would be of benefit to all
Making these changes permanent would greatly increase access for women living in poverty and those in rural communities.
Abortion is a big decision and is not undertaken lightly. Therefore home use is not a significant factor.

See question 7. People who are economically disadvantaged even here have possibly the greatest access to any abortion service offered. I guess if they live on the street they don't have an address to post the pills to, I have been involved with some of them in recent years in the course of voluntary work. Example of an economically disadvantaged street where a good friend lives ..... she was so saddened by a neighbour onto her 7th abortion and boasting about it, said it was better than bothering with contraception, obviously access to abortion was easy, a quick phonecall even better. 1967 wasn't meant to allow abortion on demand.
It would improve access for all women especially those in rural areas or in poverty
The courier service has proven very positive results so far as, the women do not have to leave their house therefore, no need to travel which could incur costs for petrol, taxi, buses, trains or simply relying on someone to bring them to clinic. Some women have very limited funds, also childcare costs.
National abortion statistics show that women in more deprived circumstances are more likely to need to access abortion services. We also know from national statistics that they are more likely to rely on benefits, less likely to have access to private transport, more likely to work in jobs with poor benefits or zero-hour contracts where sick pay is minimal or non-existent, and less likely to be able to afford childcare. If women are required to attend clinics, more deprived women will be put in the most difficult position. • Abortion providers report that women on lower incomes may often struggle to access clinics – asking providers to delay appointments until they are next paid so that they can afford to travel. This delays their appointments and increases average gestation – increasing their risk of complications. This is supported by Scottish abortion figures which show that women in more deprived circumstances are disproportionately likely to have later abortions.
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It would assist women from economically depressed areas where transport to clinics may be difficult or expensive not to have to take time off work to attend and not to have to incur travelling expenses.
Less burden to travel. Would increase accessibility, close economic gaps.
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It would increase access, as people who are more disadvantaged or live remotely cannot easily get in to see a doctor. Because of time and travel costs.
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Those who require abortions but can not afford to travel to appointments or would have difficulty reaching them due to distance or any other matter would be provided with much more accessible care, increasing the amount of women reaching out for the appropriate care as in the past they may have been reluctant to attempt to reach out as they knew these barriers would prevent them from accessing the care they required, yet these new provisions would eliminate these issues preventing them to resorting to other methods or decisions that are not right for them as an individual.
Positive, as above. Not needing to travel which if they do not have a car can be rather costly on public transport.
Those that live in rural areas are at a huge disadvantage and this measure means that accessibility will be equalised.

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I consider that these inequalities will be reduced.
for people from economically disadvantaged or geographical areas making permanent home use for EMA would have a massive benefit, as many of the people in these groups may find it to expensive or inconvenient to attend a clinic. therefore in some of these cases this would increase access to medical termination. However, that said, some patients that are economical disadvantaged may not have access to telephones, therefore they would be less likely to contact clinics for consultations over the phone, this then leading to possible unwanted pregnancies due to being disadvantaged.
National abortion statistics show that women in more deprived circumstances are more likely to need to access abortion services. We also know from national statistics that they are more likely to rely on benefits, less likely to have access to private transport, more likely to work in jobs with poor benefits or zero-hour contracts where sick pay is minimal or non-existent, and less likely to be able to afford childcare. If women are required to attend clinics, more deprived women will be put in the most difficult position. • Abortion providers report that women on lower incomes may often struggle to access clinics – asking providers to delay appointments until they are next paid so that they can afford to travel. This delays their appointments and increases average gestation – increasing their risk of complications. This is supported by Scottish abortion figures which show that women in more deprived circumstances are disproportionately likely to have later abortions.
No comment
Poverty can drive women towards abortion. Statistics from the Department of Health and Social Care reveal that “Women living in more deprived areas are more likely to have abortions than women living in less deprived areas. The rate in the most deprived decile is 26.1 per 1000 women. This is more than double the rate in the least deprived decile of 12.0 per 1000 women. Abortion is not a solution for poverty. There is a risk that abortion pills by post will be promoted as being especially important for women in deprived areas. The ease and speed of getting abortion pills will mean that women who are considering abortion for financial reasons have less time to make their decision. Critically, abortion (under current temporary measures) could mean that women do not get the help they need to deal with their circumstances.
No significant change
This isn't about access to a concluded issue - just because someone may seek abortion help and support doesn't mean once presented with objected support that they might otherwise make a more informed decision about continuing with the pregnancy.

I feel it will be hard for them and I need to be able to access a clinician personally for support and disadvantaged people wont be able to seek this as it's not easier accessible
Got to be better and more timely for rural and poorly served communities with gig hours and no transport network or lots of Wales
See previous answers. Same applies.
Disadvantaged/deprived women are going to have many more problems accessing a clinic. Rural women have to travel further. Enabling women to use the pills at home reduces the variety of burdens many women would face.
It will help women on lower incomes who struggle to find the funds for transportation.
It will considerably reduce the difference in access to abortion
I think it would increase enormously as women would not have to be in physical proximity to a clinic. They can instead pick up the pills from their local pharmacy once they have been prescribed. That said, women who would rather visit the clinic for the pills should be able to do so.
National abortion statistics show that women living in more deprived circumstances are more likely to need to access an abortion. These statistics also show that they are more likely to rely on benefits, less likely to have access to private transport, more likely to work in jobs where sick pay is minimal or non-existent, and are less likely to be able to afford childcare. If women are required to attend clinics, more deprived women will struggle to access timely care. Abortion providers report that women on lower incomes often ask for appointments to be postponed until they are next paid wages/benefits so that they can afford to travel. This increases average gestation which increases their risk of complications.
It would mean that women who are more economically disadvantaged and/or geographically isolated are more liekly to get a safe legal abortion and so are protected and helped.
I don't think there would be dramatic change in the number of women accessing it but it could make it a less stressful experience
It will increase access to people who are economically disadvantaged and people in rural areas, who seriously struggle to access so many services, and should not be struggling to make these choices about their bodies and their health.
It would make access much easier esp for those in rural areas or with our transport.
Women from poorer backgrounds are more likely to make use of these pills. Women should not be coerced into home abortion by financial constraints.
No comment.
Mantais fawr i'r bobl hynny.
Any ‘perceived’ benefit in women not having to travel to a clinic is outweighed by the negative risks to women.
Poverty is a strongly linked with abortion. The rate in the most deprived, is more than double the rate of the least deprived. Abortion is not a solution for poverty. There is more chance of those with financial reasons for abortion, making a hasty decision, given the ease and speed of obtaining pills. The chance of getting help and support for their problems would be a great loss.
The rate of abortion in the most deprived areas has been found to be double that in the most advantaged areas.Those women seeking abortion in the deprived areas are missing out in terms of counselling and medical help ,Apart from killing the unborn child, unsupervised abortion exposes the woman to real physical and mental health risks,as described under Q:3.
Like I mentioned, it is costly to have to travel to meet someone in person. Especially for something so simple and safe to do at home. It would greatly benefit people who do not have the privilege of time and money.
Should not be allowed
Poverty can drive women towards abortion, nor is abortion a solution for poverty. All women need to have an in-clinic assessment as part of their abortion care pathway. Access to abortion should be less important than the safety of the woman. Financial assistance could be provided to women in poverty to enable women to travel to have an in-person clinical assessment prior to an early medical abortion.
We need to educate the children properly in the need for babies to be brought into the world in safe families with two loving parents one of each sex and stop killing unborn children.
Poverty can drive women towards abortion, nor is abortion a solution for poverty. All women need to have an in-clinic assessment as part of their abortion care pathway. Access to abortion should be less important than the safety of the woman. Financial assistance could be provided to women in poverty to enable women to travel to have an in-person clinical assessment prior to an early medical abortion.
Poverty can drive women towards abortion, nor is abortion a solution for poverty. All women need to have an in-clinic assessment as part of their abortion care pathway. Access to abortion should be less important than the safety of the woman. Financial assistance could be provided to women in poverty to enable women to travel to have an in-person clinical assessment prior to an early medical abortion.
It could lead to possible coercion of poorer and disadvantaged ladies by male exploiters.
This should be an open debate in the parliament chamber on the value placed on a human life .
It is likely that making it permanent will increase access to the abortion, overall, in areas with different levels of poverty; I am unsure whether the level of increase will be different in different areas.

Poverty can drive women towards abortion. Statistics from the Department of Health and Social Care reveal that “Women living in more deprived areas are more likely to have abortions than women living in less deprived areas. The rate in the most deprived decile is 26.1 per 1000 women. This is more than double the rate in the least deprived decile of 12.0 per 1000 women.”15 • Abortion is not a solution for poverty. There is a risk that abortion pills by post will be promoted as being especially important for women in deprived areas. The ease and speed of getting abortion pills will mean that women who are considering abortion for financial reasons have less time to make their decision. Critically, DIY abortion could mean that women do not get the help they need to deal with their circumstances.
It would make access far easier and safer for all groups, reducing the need to travel, particularly if the person doesn't drive and would have to pay for a taxi or rely on public transport
Too involved a question for me to answer.
Poverty can drive women towards abortion, nor is abortion a solution for poverty. All women need to have an in-clinic assessment as part of their abortion care pathway. Access to abortion should be less important than the safety of the woman. Financial assistance could be provided to women in poverty to enable women to travel to have an in-person clinical assessment prior to an early medical abortion.
Homeless women - Cannot get pills posted to them Women concerned about getting into poverty
The safety of women and children should be of more concern than access to abortion. Should not funds be provided to help poorer women get to a clinic rather than extending this temporary measure which has, and has caused, so many problems (see above)?
I think continued use of termination at home with both medications is beneficial. People who would not be willing to come to a clinic can access our service with ease. Costs to patients are reduced as we cover a large geographical area and provide bases that the medications can be collected from within different areas so travelling costs can be greatly reduced.
I believe it would increase abortion figures.
I think it would increase levels of abortion. I think we would also continue to see women seek terminations at an earlier gestation knowing that, certain communities who cant afford a taxi, bus or means of transport to attend multiple appointments, can receive the medical treatment in a timely manner.
The making permanent of the home use of abortion seems almost certain to increase the incidence of abortion in all socio-economic groups. Ease of access is hardly a worthy criterion in a civilised society.
Easier access for some people would be outweighed by the potentially life-changing effects of an abortion. This is a most serious procedure and needs to be taken with all the medical factors taken into account by a face-to-face consultation with a doctor. A phone call is totally insufficient.
People who are economically disadvantaged are the ones most in need of care and support which home use cannot provide.
Access to abortion needs to be discussed with a healthcare professional face to face. Wouldn't making home abortions in this way, just increase the promiscuity amongst some women?
National abortion statistics show that women in more deprived circumstances are more likely to need to access abortion services. They are also more likely to rely on benefits, lack access to private transport, work in jobs with poor pay and are less likely to be able to pay for childcare. They therefore find it much more difficult to attend clinics in person. Delays to care due to the need to save the money needed to travel results in a increase in average gestation, increasing the risk of complications.
I think that something as important as an abortion is worth travelling to the nearest clinic for
bad for everyone - so stop it now
It makes it dead easy to kill unborn babies without any checks and balances and cheaply. Is this what our society has come to?
Poverty is not an excuse for telemedicine abortion. Financial assistance should be provided so that the woman receive the personal care she needs
It would probably increase the rate of abortion in deprived areas since statistics show that women living in such areas are more likely to have abortions than women living in less deprived areas. Neither would they get the help they needed to deal with their circumstances.
Women suffering financial hardship may feel they can't afford to have a baby and feel driven to have an abortion. Providing abortions at home does not solve the root cause of this poverty. The safest approach would be to assist the women with transport costs to a clinic, where she can be properly assessed.
If people want an abortion, they will access services to get one. I have taken the morning after pill in the past, and believe me, it was a priority for me. Making permanent home use of both pills only takes proper healthcare services away from poorer women. If you want to make the service better for poorer women, have early morning or late evening clinics, so that they can access proper treatment there, including a clinical assessment before taking a pill.
This is another difficult question.
Poverty can drive women towards abortion, nor is abortion a solution for poverty.

All women need to have an in-clinic assessment as part of their abortion care pathway. Access to abortion should be less important than the safety of the woman. Financial assistance could be provided to women in poverty to enable women to travel to have an in-person clinical assessment prior to an early medical abortion.
As has been stated in earlier questions it is important that a pregnant woman receives an in clinic assessment before any abortion takes place as this is the only way of ensuring the best care pathway. As some women may not be able to afford to attend an abortion clinic the most sensible solution is that financial aid should be available to prevent inequality between different financial starters of society.
I think there should be much better safer ways to make provision for people who are at disadvantage than leaving them to DIY at home without the level of support they need.
There are many hidden costs to accessing in-person abortion care services, most prohibitively child-care, organising time off work, and travel. ● In England and Wales there is a strong association between deprivation and abortion, with the rate in the most deprive decile (26.1 per 1000 women) being more than double the rate in the least deprived decile (12.20 per 1000 women) 14 ; attempts to revoke temporary regulatory changes would therefore disproportionately affect women of lower socio-economic status. ● Expanding telemedicine services would clearly alleviate some of these financial burdens by allowing flexibility in accessing remote services and actually managing an abortion at home.
Those from remote/rural or deprived backgrounds benefit the most from telemedicine as it allows access to abortion care earlier (which is safer) and reduces the patient costs of abortion care: transport/parking/childcare/loss of earnings/loss of privacy (having to disclose pregnancy/abortion in order to get time off work)
Provision of medicines particularly by post improves access to provision by those most disadvantaged economically and geographically
I think it would increase the incidences of abortion in more economically disadvantaged areas since it might appear as the only option available. This is morally reprehensible and would be a complete failure of all the efforts to raise standards across the board in Wales. It would also be a dreadful lesson to future generations.
It would provide abortion for teasons it was never intended.
I think this should definitely not be made available.
It would increase access for disadvantaged groups to a great extent.
I think that those in rural areas may consider it an advantage to have the pills by post rather than attending a clinic. However if women in rural areas suffer complications they are further from the health care services that they need to treat them.
I think it would reduce the differential as stated above by making access easier and cheaper.
Do not know
It would reduce differential access to those living in remote communities, in those without funds to travel, women who are single parents with young children.
Abortion is not the answer to poverty. The cost of a bus fare should be addressed in other ways.
People living in disadvantaged areas may not have access to mobile phones/ landlines/ internet access or the ability to make outgoing calls. This is immediately putting those people at a disadvantage if face to face consultations are not available. People living in remote areas may be disadvantaged. They will not have the same opportunity to seek help quickly or conveniently due to limited health care services. I t would be better for patients in rural areas to be in a health care setting for the procedure to take place to minimise risk as much as possible.
The current arrangements may have a positive impact on women living in lower socio-economic circumstances or those who are living in poverty. However consideration needs to be given to women who may not have a permanent residence or are homeless. Accessing Early Medical Abortion over the telephone avoids travel costs to clinic appointments and for those on 0 hours contracts, casual work or cash in hand payments do not have to face loss of income by taking time off work to attend appointments. There is also the possibility that the permanent home use of both pills for Early Medical Abortion could increase the difference in access to abortion for people between geographical areas with different levels of disadvantages. Across Wales the access to broadband services ranges significantly. The average download speed ranges from 24.5Mbit/s in Powys to 61.0 Mbit/s in Cardiff (https://gov.wales/sites/default/files/statistics-and-research/2019-05/summary-statistics-for-welsh-economic-regions-wales-338_0.pdf). Whilst this will not have a direct effect on the use of both pills at home, it will have an effect on the woman's ability to take part in consultations and video/phone calls with health professionals. However, on the other hand the rurality of Wales and access to health care services has been a historic challenge. The use of online consultations and continuing the temporary arrangements of taking both pills for Early Medical Abortion at home would mitigate this challenge and improve access to healthcare services in rural Wales. A victim of domestic abuse or a member of a large or religious family may be unable to guarantee the privacy needed to have an online consultation with a healthcare professional. Privacy and ensuring the individual is seeking the service of their own will is necessary, especially for a service of this nature. Therefore making the current arrangements exclusively online and taking both pills at home may not be suitable for all individuals requiring the services. To ensure the impact of economic, health and social inequalities are mitigated, individuals should have the choice as to where they receive their treatment, at home or in a clinical setting
Poverty can drive women towards abortion, nor is abortion a solution for poverty. All women need to have an in-clinic assessment as part of their abortion care pathway.

Access to abortion should be less important than the safety of the woman. Financial assistance could be provided to women in poverty to enable women to travel to have an in-person clinical assessment prior to an early medical abortion.
I think most women can gain access to these services anyway without using home abortions.
Poverty can drive women to abortion. Abortion is not the solution to poverty. All women need in-clinic assessments. Access to abortion should be less important than the safety of the women. Financial assistance could be provided to women in poverty so they can travel to inperson clinical assessments prior to an early medical abortion.
The differential effect of making permanent the home use of both pills for EMA is unclear. It is clear though that clients provided with both pills for home use without thorough clinical assessment are receiving a lower standard of care than would normally be available to them. Ease of access should not be allowed to trump safety considerations. If there are difficulties accessing a clinic for appropriate care, then this should be the focus of concern, rather than trying to increase access to a poorer service. It should also be overtly acknowledged that provision of abortion is not a solution for social deprivation or economic disadvantage.
I don't agree with home pills at all, all women are normally able to access a medical practice
If young women had more education regarding a loving relationship and didn't feel pressured into having a sexual relationship from the start, and then were provided with contraception if they entered into a sexual relationship later on this question would not have to be asked.
• Poverty can drive women towards abortion. Statistics from the Department of Health and Social Care reveal that "Women living in more deprived areas are more likely to have abortions than women living in less deprived areas. The rate in the most deprived decile is 26.1 per 1000 women. This is more than double the rate in the least deprived decile of 12.0 per 1000 women." (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_ data/file/891405/abortion-statistics-commentary-2019.pdf) • Abortion is not a solution for poverty. There is a risk that abortion pills by post will be promoted as being especially important for women in deprived areas. The ease and speed of getting abortion pills will mean that women who are considering abortion for financial reasons have less time to make their decision. Critically, DIY abortion could mean that women do not get the help they need to deal with their circumstances.
If women in disadvantaged areas or remote areas have difficulty in attending a clinic, then N.H.S. Wales should provide 'out of pocket expenses' to assist with travel. Abortion is not a solution to poverty. The safety and well being of the woman should be paramount.
Geographical areas and " disadvantage" levels are hardly reasonable excuses for killing a baby , who is after all , very special and NOT an animal!
As abortion clinics are mostly in larger towns and cities, women in rural areas often struggle to attend an in-person clinic appointment. Thus, pre-home-use provision disadvantages women who live outside of towns and cities (Romanis, et al, COVID-19 and Reproductive Justice, 2020: https://academic.oup.com/jlb/article/7/1/lsaa027/5838025); Aiken and others, Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain, 2018, https://pubmed.ncbi.nlm.nih.gov/28941978/). This disadvantage will be greater for women who struggle to obtain childcare, are required to take time from work (which may be unpaid), and do not have access to private transport. Thus, a requirement for in-clinic appointments is discriminatory for women from low-income households.
Abortion clinics are awful places to be but the difference between geographical areas and NHS/Private is huge. Home use can change this massively
I disapprove of home use of both pills
The safety of all women, whatever their geographical location or level of deprivation is paramount. Access is less important than safety. Safe provision can only take place with an in-person clinical consultation. We propose that where necessary, funding is provided for transport to enable the clinical assessment.
As outlined above - it pathes the way to greater unregulated purchase of abortion pills online. It seems inevitable that some will seek tablets without any desire to use them for themselves.
I think it would definitely reduce the difference in access to abortion services for poorer areas or to people living much further away from the provider.
• National abortion statistics show that women in more deprived circumstances are more likely to need to access abortion services. We also know from national statistics that they are more likely to rely on benefits, less likely to have access to private transport, more likely to work in jobs with poor benefits or zero-hour contracts where sick pay is minimal or non-existent, and less likely to be able to afford childcare. If women are required to attend clinics, more deprived women will be put in the most difficult position. • Abortion providers report that women on lower incomes may often struggle to access clinics – asking providers to delay appointments until they are next paid so that they can afford to travel. This delays their appointments and increases average gestation – increasing their risk of complications. This is supported by Scottish abortion figures which show that women in more deprived circumstances are disproportionately likely to have later abortions.
It will reduce barriers to accessing services
I imagine it would reduce the differences in access to abortion.
I imagine it would make a big difference to those who are far away from clinics and for those who would struggle to get time away from work or family commitments to make appointments
There is an argument being made that home abortions will benefit women in poverty. This argument implies that home abortions can be part of the solution to poverty. The reverse is true as seeking an abortion for financial reasons should lead to women being directed to services which can help them with their financial circumstances. Home abortions could mean that women miss out on this life changing help.

Women from disadvantaged groups either economically or geographically need the same supervision and care as other people and using home pills would put them at a greater risk.
Women in more deprived groups are more likely to have later and therefore more risky abortions.
Women may not adhere to the precise time intervals between the two stages of the abortion. An ectopic pregnancy can be missed which can be life-threatening. (There is evidence from the United States that ectopic pregnancies are being missed in telemedicine. Emotional distress - the woman may be alone to deal with the remains by herself, or may be with an abuser. Comparing in-clinic assessment vs telemedicine: Clinicians able to verify identity of woman. Correctly assess gestational age. Assess suitability for abortion medically. Talk in private to check coercion. Certainty that the person present is the one taking the pills.
It is perfectly clear to me that making permanent home use of both pills for EMA will reduce the difference in access to abortion for women in more economically disadvantaged areas.
More women might seek abortion if it were easier to come by, thinking abortion would prevent greater poverty.
The economically disadvanged are likely to be affected dependant on cost,, and a range measures should be taken to see that this does not happen.
Reduce difference, digital access will make it easier, I would imagine very few women who have not gone through menopause, are digitally excluded now, although some maybe so access for those should be considered of course. Also not 'people's, women and girls are affected not biological men & boys. Not sure why you have switched to 'people'.
People? You mean women and girls! National abortion statistics show that women in more deprived circumstances are more likely to need to access abortion services. We also know from national statistics that they are more likely to rely on benefits, less likely to have access to private transport, more likely to work in jobs with poor benefits or zero-hour contracts where sick pay is minimal or non-existent, and less likely to be able to afford childcare. If women are required to attend clinics, more deprived women will be put in the most difficult position. • Abortion providers report that women on lower incomes may often struggle to access clinics – asking providers to delay appointments until they are next paid so that they can afford to travel. This delays their appointments and increases average gestation – increasing their risk of complications. This is supported by Scottish abortion figures which show that women in more deprived circumstances are disproportionately likely to have later abortions. As ever,WOMEN are the ones most vulnerable and most likely to be unable to gain access via traditional means to health care, especially in the current pandemic and the cost, travel arrangements and childcare are all burdens which fall on their shoulders whether they are single parents or co-parenting. On top of this they have to ask for time off work and often struggle through the after effects alone. Permanent home use would shift the balance of power back into the hands of the women and girls needing this vital service.
Such a measure would tip the scales towards abortion for the insecure, rather than supporting them. Many will regret their decision, and suffer mental health problems as a result.
Making permanent home use of both pills for EMA would reduce the difference in access to abortion for women at economical or geographical disadvantage.
Massively. Being able to access care remotely does a lot to level the playing field for all.
None
Financial assistance for travel should be available to women who cannot afford to have in person clinical assessment.
This is another ""closed"" question. To answer, I believe the professionals would do all in their power to ensure that delivery of the service would be equitable.
Women who live in economically disadvantaged areas are generally more likely to resort to abortion as higher numbers from such areas demonstrate. This is not a free choice being made by such women, they are being forced into abortion by their poor circumstances. The speed and ease of access to abortion pills by post would incur an increase in abortions because the women concerned would be able to make rash decisions without clearly thinking about the outcome. Abortion is not the answer to poverty. Steps must be taken by Sennedd Cymru to help poorer people.
The easy access to EMA by receiving pills by post will only increase the divide and disadvantage for people living in more deprived areas compared to people living in more affluent areas. Women living in deprived areas are more likely to have an abortion, to suffer abuse, might have less stable family ties and are less likely to access the support they need. Removing face to face consultations will not only perpetuate, but even worsen their situation.
I can say from working in a health board which has a significant proportion of patients from such deprived backgrounds, spread over a diverse geographical area that extending the use of both pills at home for EMA would be a significant forward change in healthcare equality in Wales. Women's access to abortion care since March 2020 has improved dramatically, and is now available to women who may not want or be able to come to a clinical setting. Our challenge now as healthcare providers is to continue to break down these barriers and use this as an opportunity to provide safe and effective healthcare to all women in Wales.

Abortion is not an excuse for poverty. Solutions, to alleviate pressures on women living in deprived area to abort, would help level the cultural differences in society.
The cost of travel to a clinic is removed, and working women can time their use of the pills to fit in with their work schedule.
Poverty can drive women towards abortion, nor is abortion a solution for poverty. All women need to have an in-clinic assessment as part of their abortion care pathway. Access to abortion should be less important than the safety of the woman. Financial assistance could be provided to women in poverty to enable women to travel to have an in-person clinical assessment prior to an early medical abortion.
People from 'economically disadvantaged areas or between geographical areas with different levels of disadvantage' should be supported even more and thus need professional medical help in this difficult situation.
It will probably increase the numbers of abortions because it makes abortion quicker and easier to obtain. It is a massive liberalising measure.
There should be no permanent use of these pills in a home setting so whatever economic and geographical area or level of disadvantage there might be - it still should be assessed and administered by a clinician .
There are many hidden costs to accessing in-person abortion care services, most prohibitively child-care, organising time off work, and travel. ● In England and Wales there is a strong association between deprivation and abortion, with the rate in the most deprive decile (26.1 per 1000 women) being more than double the rate in the least deprived decile (12.20 per 1000 women); attempts to revoke temporary regulatory changes would therefore disproportionately affect women of lower socio-economic status. ● Expanding telemedicine services would clearly alleviate some of these financial burdens by allowing flexibility in accessing remote services and actually managing an abortion at home.
Every year there is a strong association between the lowest deprivation deciles and higher rates of abortion hence removing home-use of mifepristone will disproportionally affect women who are poorer. Not having to travel to clinics will clearly improve care for people in geographically isolated areas.
Permanent change would reduce the differences in access to abortion. There are obvious monetary costs of attending hospital for assessment and treatment, but also hidden costs of time, childcare, social judgement.
Byddai lot yn haws i ferched sy'n byw yn bell o wasanaethau erthyliad mewn rhai rhannau o Gymru e.e. gogledd Cymru
Making home abortion permanently available might well make it easier for women from disadvantaged areas to access abortion, but at the same time it deprives them of the medical care and support they would receive if they attended a clinic. The safety and wellbeing of the woman is a more important consideration than the ease of access to abortion.
See my earlier example of the train fare!!
As statistics show from the Depart. of Health and social care that women living in most deprive areas is 26.1 per 1000 compared with 12.0 per 1000 in the least deprived areas . As getting the pills can be a quicker way of getting out of financial problems. the women in the depressed area does not get the help she really needs to deal with her problem.
Abortion is already very easily accessible in the UK, in all geographical regions. Making the temporary measure permanent will have little impact in terms of its availability for women in economically disadvantaged situations. It might make it more convenient for some women to undergo abortion without the need to travel for clinic appointments or consultations. Convenience, however, should never override safety in healthcare provision.
I believe it would increase access to abortion for all. With increased danger for those living in rural areas, who may find it harder to access help when needed, and for the economically disadvantaged, who may need more personal support than other groups.
Complications from medical abortion sometimes require emergency medical treatment, which can be difficult to access for women living in economically disadvantaged areas. For this reason, early medical terminations at home should certainly not be allowed in remote areas (indeed, early medical terminations at home should not be permitted in any part of Wales). A large Finnish register study found that 15.6% of women who had a medical abortion accessed hospital care for bleeding, one fifth of whom required intervention. Should a woman living in a disadvantaged area need emergency medical care during or following an early medical abortion at home, she may not be able to access that care quickly – increasing the risk to her health. • There is a risk that abortion pills by post will be promoted as being especially important for women in deprived areas. The ease and speed of getting abortion pills will mean that women who are considering abortion for financial reasons have less time to make their decision. Critically, home abortion could mean that women do not get the help they need to deal with their circumstances.
There will always be theses marginalised by lack of internet access or cognitive impairments making anything other than face to face communication extremely difficult.
We acknowledge that some women live at distance from their nearest abortion clinic and do not have easy or affordable access to transport. In some case her partner may not allow her access to family/household monies. Our recommendation is that rather than relying solely on telemedicine, it would be safer and more effective to provide financial assistance to those women who need it, to cover their out of pocket expenses for travel, time away from paid employment, childcare costs, and any necessary overnight stays. This is already a proven process for women living in Northern Ireland who have to travel to England to access services.
Generally, women who are the most deprived disproportionately have the highest need for abortion care, due to other barriers they face. Further, as mentioned above, it has been shown that vulnerable groups, including those who

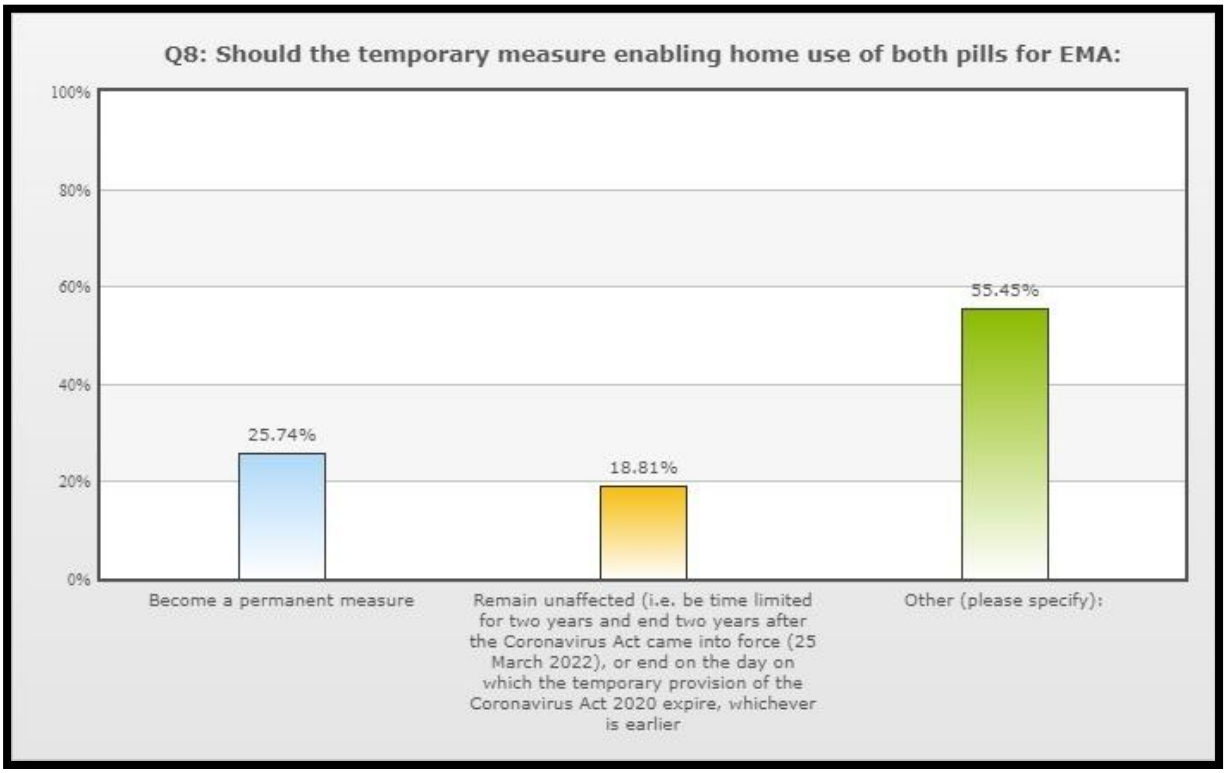
are socio-economically disadvantaged, face additional barriers when attempting to access abortion care. For example, the requirement to travel for in person care presents several financial issues to overcome, including the cost of travel to an abortion clinic, the cost of childcare, and of work absence, particularly as this group is more likely to be employed in precarious work or on zero hours contracts. As a result of these barriers, often, women in these groups will turn to illegal unregulated online providers of abortifacients like Women on the Web (WotW). This was demonstrated by a 2017 study in which researchers contacted 519 women from England, Scotland, and Wales who had contacted WotW seeking abortion medication. One hundred and eighty women responded, reporting 209 reasons for seeking abortion outside the formal healthcare setting. Among all reasons, 49% were access barriers, including long waiting times, distance to clinic, work or childcare commitments, and lack of eligibility for free NHS services. (https://www.contraceptionjournal.org/article/S0010-7824(17)30435-3/pdf) However, a recently published study suggests the EMA at home model has increased accessibility for women who previously might previously have relied on unregulated online providers of abortifacients. This study compared the number of requests to the online telemedicine service Women on Web in eight European countries before and after they implemented lockdown measures to slow COVID-19 transmission. The study found that in five European countries where abortion services are mainly provided in hospitals or where no abortion services are available requests to Women on the Web increased. Whereas in Britain, following the introduction of the EMA at home model, there was an 88% decrease in requests. The implication is that those previously too vulnerable to attend in-person were able to access care through the EMA at home model. (https://srh.bmj.com/content/early/2021/01/11/bmjsrh-2020-200880.full.pdf) By removing many of the barriers created for socio-economically disadvantaged groups, for example, by removing the need for travel, the need to take time off work, and to pay for childcare, and allowing women to take the medication in their own home, the EMA at home model will facilitate better access to safe, regulated abortion care for socio-economically disadvantaged groups thus reducing the difference in access to abortion for women from more deprived backgrounds or between geographical areas with different levels of disadvantage. Facilitating better access to abortion care for socio-economically disadvantaged groups is not only important to respect those individuals' rights to health, and to non-discrimination, but it is also likely to have a broadly positive impact on long-term social and economic equality in England. A significant number of international studies have found that by reducing rates of unintended pregnancy, increased access to abortion increases educational attainment and labour market participation amongst women. (See for example: https://iwpr.org/iwpr-issues/reproductive-health/the-economic-effects-of-abortion-access-a-review-of-the-evidence/)
It will help reduce differential access to abortion particularly amongst economically disadvantaged groups. It will help those living in more remote areas where travel arrangements are more complex and expensive. It will help those economically disadvantaged due to reductions in cost of travel and time off work, which they can ill afford, or in easier child care arrangements.
Some patients experience the degree of financial hardship that makes journeys unaffordable. In Cardiff and Vale UHB we cover a large geographical area, not just the city.
I think this will reduce the difference in access to abortion. Those on low income can often not afford take time off work.
All women need to have an in-clinic assessment as part of their abortion care pathway. Access to abortion should be less important than the safety of the woman.
It would reduce travel for women who live in remote areas or who do not have access to transport.
Poverty can drive women towards abortion, nor is abortion a solution for poverty. All women need to have an in-clinic assessment as part of their abortion care pathway. Access to abortion should be less important than the safety of the woman. Financial assistance could be provided to women in poverty to enable women to travel to have an in-person clinical assessment prior to an early medical abortion.
In the 20th Century, socio-economic status should not impact a person's ability to access reproductive healthcare, but sadly it does. There are hidden costs to accessing abortion services, some of which are removed by early medical abortion at home. National abortion statistics show that women in more deprived circumstances are more likely to need to access abortion services. We also know from national statistics that they are: - Less likely to have access to private transport – meaning they often rely heavily on public transport which may affect the cost, time, and difficulty of attending an in-person appointment. - More likely to work in jobs with poor benefits or zero-hour contracts where sick pay is minimal or non-existent - which may make it more difficult to get time off work for appointments and to pass the pregnancy in the days subsequent to the appointment - Less likely to be able to afford childcare – creating another barrier for accessing care, as if a woman cannot afford to pay for childcare whilst she attends an in clinic appointment she is likely to delay, or not access care at all. Abortion providers report that women on lower incomes may often struggle to access clinics – asking providers to delay appointments until they are next paid so that they can afford travel or childcare. This delays their appointments and increases average gestation – increasing their risk of complications. Requiring women to attend clinics disproportionately negatively impacts women from disadvantaged backgrounds.

As noted in my response to the previous question, socioeconomic disadvantage means that access to abortion care has never been equal. We often speak of ""abortion deserts"" in the United States, but they do still exist in the United Kingdom. Making these changes permanent will mean that financial barriers will no longer prevent people from accessing abortion care.
There are many hidden costs to accessing in-person abortion services, most prohibitively childcare, organising time off work, and travel. In England and Wales there is a strong association between deprivation and abortion, so that attempts to revoke the regulatory changes would disproportionately affect women of lower socio-economic groups.
In the 20th Century, socio-economic status should not impact one's ability to access reproductive healthcare, but sadly it does. There are hidden costs to accessing abortion services, some of which are removed by early medical abortion at home. Figures from elsewhere in the UK show that those who are most deprived are more than twice as likely to need to access abortion services as women who are least deprived and are disproportionately likely to access services later in pregnancy. BPAS knows that more deprived women are disproportionately likely to ask us to delay care that requires them to travel until they are next paid or receive their benefits – because existing NHS travel costs schemes do not fund self-referred abortion travel. Women face structural issues of socio-economic disadvantage which may leave them struggling to access care which provided from specialised clinics or hospitals, including: • The high cost of childcare • Families where women do not have access to an independent income and wish to keep their travel and treatment private • The disproportionate likelihood of being employed in precarious jobs or with zero-hours contracts, which may make it more difficult to get time off work for appointments and to pass the pregnancy in the days subsequent to the appointment • Disproportionate reliance on public transport which affects the cost, time, and difficulty of attending an in-person appointment – particularly in more rural and remote areas
This is outside our remit, but suspect that it will increase equality of access.
Poverty can drive women towards abortion, nor is abortion a solution for poverty. All women need to have an in-clinic assessment as part of their abortion care pathway.
Making these measures permanent will most definitely reduce the geographical and socioeconomic inequalities that have been seen in access to abortion care in Wales. Prior to the changes women in Wales were twice as likely to pay privately for abortion care than Women in England. This was not because they are richer than Women in England, but because they found it more difficult to access free abortion care in Wales. These temporary measures have improved women's access to abortion care in Wales.
it will make access more equable- have worked as a GP in deprived housing estate for decades so I have xperience behind my answers
There is substantial geographical inequality in access to abortion services across Wales because clinics are concentrated in metropolitan areas. For many people accessing abortion means incurring significant cost because of the travel involved, organising childcare for any existing children or other dependents, and taking time off work. These concerns will be particularly significant for individuals with less disposable income, or live in areas that are further from larger cities and therefore the distance to travel is more significant (Romanis, Parsons, and Hodson 2020). There is no doubt that this places a substantial barrier in access for many, and can even result in delays in treatment because of the logistics involved in arranging a clinic visit. Remote consultation and home use of the medications can improve access by enabling these groups to access care without having to make the same sacrifices that might be difficult for them to afford, or to arrange. References: Romanis, EC, Parsons JA, and Hodson, N. 2020. 'COVID-19 and Reproductive Justice in Great Britain and the United States: ensuring access to abortion care during a global pandemic.' Journal of Law and the Biosciences https://academic.oup.com/jlb/article/7/1/lsaa027/5838025
More abortions are likely with self administered terminations but the longer term psychological impact at a later date will become apparent. therfore not cost efficient if this increases greater need for mental health services
The health and wellbeing of women should be more important than access to abortion. Poverty often drives women to have an abortion, but abortion is not a solution to poverty.
To answer this question accurately it is important that the relevant data concerning uptake by these respective groups is made available, regularly updated and carefully monitored.
I have no data to support or dent this point . What does the recent data published suggest? What is your interpretation of that /
Deprivation and geographical isolation are primary factors in driving women and girls into seeing abortion as the only solution to what they have been told is detrimental to their position and to ignore the dangers of the use of very intrusive drugs.
Those in poverty are more likely to be driven to having an abortion which is not the answer to poverty. Poorer women need support and care to enable them to make a choice that they really want to make and not the decision that their socio economic situation forces them into. All women need safe medical provision. A face to face consultation in a safe place i.e. a clinic is vital in reducing the inherent risk of what is effectively an anonymous early home abortion by phone and post.
NEVER
Poverty can drive women towards abortion, nor is abortion a solution for poverty. All women need to have an in-clinic assessment as part of their abortion care pathway.

Access to abortion should be less important than the safety of the woman. Financial assistance could be provided to women in poverty to enable women to travel to have an in-person clinical assessment prior to an early medical abortion.
Every pregnant woman, regardless of social background and circumstances, should have access to a face-to-face medical assessment before proceeding to undergo an early abortion. Women's safety, and that of the baby, should be paramount in any consideration of making permanent home use of both pills.
I cannot see it would make any difference, as medial services are available to all. Making home use of abortion medication readily available would increase the abuse of these drugs and allow people to force women to have an abortion against their will.
Poverty can drive women towards abortion. Abortion is not a solution for poverty. All women - from whatever background or economic status - should have an in-clinic assessment as part of their abortion care pathway. A woman's safety should always be more important that her access to abortion. Financial assistance could be provided to women in poverty to enable them to travel to a in-person appointment at the clinic.
The differences in access will increase. People from economically disadvantaged areas are akready subject to inequalities of health care, for example those on the poverty line or the homeless. Continued restricted access t this area of health will not help their underlying health needs. People in remote areas will be more at risk from complications and unable to access adequate care. In-person consultation is significantly more appropriate for both groups of people.
It would not change it.
This question ignores the fact that women from more economically disadvantaged or isolated areas may find it more difficult to become aware of, and access, positive support with their pregnancies. Many women would prefer to take their pregnancies to term, and are unaware of help available to them to do so, whether from the State or from voluntary organisations. Those in this situation, who will disproportionately include disadvantaged women and those with communication problems such as migrants, should not have their abortions rushed forward; rather, positive help with their pregnancies should be better advertised to them. With regard to women living in isolated areas, such women are at particular risk if they experience issues after a home abortion such as uncontrolled bleeding or sepsis. They are also less likely to have immediate access to women's shelters, for example, in the case of those being pressured to abort by a partner.
Poverty can drive women towards abortion. Access to abortion should be less important than the safety of the woman. Maybe some financial assistance could be provided where necessary to enable women to travel to an in-person clinical assessment prior to an early medical abortion.
people who are economically or geographically disadvantaged deserve the best care and such disadvantage should not trump safeguarding.
We can see issues involved in people living at a distance from emergency services. The risks are in women who are experiencing complications and need emergency intervention but are not close enough to emergency services. These situations can have grave life threatening consequences.
As an organisation working with thousands of churches across the whole of Wales and the rest of the United Kingdom, many of them in the most deprived communities, we are deeply concerned for pregnant women living in such economically disadvantaged areas. Studies show in England that the abortion rate in the most deprived decile is 26.1 per 1000 women while the rate is 12.0 per 1000 in the least deprived IMD decile (Department of Health and Social Care 2021. [online] Available at: <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/891405/abortion-statistics-commentary-2019.pdf> [Accessed 23 February 2021].). The case for wanting a more democratic approach towards accessing abortions is besides the point, as there is already a higher rate of abortions within the most deprived communities, regardless of the proposed legislation. To properly support women from deprived women better in these circumstances, the Government should subsidise or fund in-person appointments (similarly to Northern Ireland) rather than having easier access to medical abortion pills.
I can't fully answer this question
Women from different geographical areas, particularly in Wales will be impacted differently . Those in more remote rural areas may find not travelling to a face to face consultation a benefit but this can have a detrimental impact if complications occur as a result of the abortion as medical help will be more difficult to access. The permanent extension of DIY home abortions presents disproportionate problems for those with social, economic

or geographical exclusion. In-person consultation would seem more appropriate than remote consultation in every case and alleviate many of the inequalities.
In making such a magnanimous gesture to make both pills for EMA available at home for the economically and geographically disadvantaged are you not in effect working to cull the population of people who are on low wages/single parents etc? A child born into a family of lower income is not necessarily less loved or wanted than a child born into affluence and privilege. And do geographically remote areas need to be devoid of children for the sake of underfunded health facilities? Why should a woman living in an inner city location feel that she must terminate her child because she cannot access a local GP? This is a crisis of local and national government: women should not have to pay the price in expelling a foetus at home because they cannot get a face to face appointment with a medical professional.
I think it would reduce the difference in access.
This increases the difference in access, because people from more economically disadvantaged areas have less access to the technology which enables remote video consultations, or access to private telephones.
DIY abortions can increase abuse for pregnant women. Pregnant women who are abused are at greater risk from abortion. Religion or belief for healthcare workers who are asked indirectly to be involved with this service, eg. posting pills. Poverty can drive women towards abortion, nor is abortion a solution for poverty. All women need to have an in-clinic assessment as part of their abortion care pathway. Access to abortion should be less important than the safety of the woman.
- Poverty can drive women towards abortion, nor is abortion a solution for poverty. - All women need to have an in-clinic assessment as part of their abortion care pathway. - Access to abortion should be less important than the safety of the woman. - Financial assistance could be provided to women in poverty to enable women to travel to have an in-person clinical assessment prior to an early medical abortion.
Is there any evidence from before the pandemic that there was a significant 'difference in access'? One difference I have noticed, anecdotally, is that certain groups may have been given even less time and discussion around their decision, for example younger people (15-19) have often reported that they felt they were seen as 'silly little girls', and they were not given any information about support if they continued with the pregnancy. Again, it's hard to imagine a telephone consultation would make such situations any better.
There are many hidden costs to accessing in-person abortion care services, most prohibitively child-care, organising time off work, and travel. In England and Wales there is a strong association between deprivation and abortion, with the rate in the most deprive decile (26.1 per 1000 women) being more than double the rate in the least deprived decile (12.20 per 1000 women) (1); attempts to revoke temporary regulatory changes would therefore disproportionately affect women of lower socio-economic status. Expanding telemedicine services would clearly alleviate some of these financial burdens by allowing flexibility in accessing remote services and actually managing an abortion at home. (1) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/891405/abortion-statistics-commentary-2019.pdf
1) Official abortion statistics show that poverty is a significant factor in women's decision to keep a pregnancy with those in the most deprived areas more than twice as likely to undergo abortion than in the least deprived areas (a rate of 26.1 per 1,000 women in the most deprived 10 per cent of the population compared to 12.0 per 1,000 women in the least deprived 10 per cent) so if there is easy access to abortifacient pills then there could be an increase in access/promotion to women in deprived areas (I have seen leaflets for abortion in a doctor's surgery in a deprived area of north west England) meaning more women could become trapped in a cycle of abuse, mental and physical health problems, multiple faltering relationships and thus more socio-economic inequality which governments seek to avoid. Without a clinic appointment and a sense that society does not care for them, women in deprivation may not seek the help they need. 2) Women in deprived areas requiring only a telephone call may feel pressured into 'DIY home abortion'. Getting abortifacient pills to women "quicker" and them being concerned about age of gestation and the inherent problems as described means women who are unsure about proceeding with an abortion could feel pressured to take them which the Welsh Government should not encourage. 3) Abortion is not a solution to poverty. In fact, motherhood can help women in poverty improve their lives with a study finding "having a baby can serve as an asset to street exit for some homeless youth including motivating discontinuation of substance abuse; parenthood can activate hope and motivation; social service agencies have an essential and ongoing role to foster and support development for mothers and their children" (Ruttan L, Laboucane-Benson P & Munro B, 2012, Does a baby help young women transition out of homelessness? Motivation, coping, and parenting. J Family Social Work 15(1):34-49.)
Abortion rates show huge socioeconomic variations and the positive impacts of the temporary regulations have assisted women from deprived socioeconomic backgrounds

Q8: Should the temporary measure enabling home use of both pills for EMA:



I cant choose either as I dont agree. It should be stopped.
The measures should end immediately. Taking abortion pills at home is promoted as being safe and simple, but it is fraught with risks and complications, as well as being traumatic for women.
Home abortions should be stopped immediately. Even if the law remains unchanged, those responsible for provision should immediately cease to recommend or enable them to take place.
Ideally EMA should be ended immediately. However, the protocol stated above would be a second option. EMA is being advertised widely as being safe and simple. It is NOT. It is fraught with dangers, as I have made clear. The Welsh Government should undertake a public information campaign to inform women, and society generally, of the risks inherent in abortion, but especially the risks inherent in EMA.
Number (3) ""End immediately"" Taking abortion pills at home as being safe and simple, but it is fraught with risk and complications as well as being traumatic for women. The government should undertake to inform all women of the risk of DIY abortions.
Such a provision should never have been made available in the first place. Children are the future of any nation. Of course there will always be difficult circumstances, but destroying our future without making a better choice can never be right. There must be better provision for those finding themselves in these difficult places, not just getting rid of some inconvenience. Marriage, the family and the well being of this nation needs to be nurtured, not destroyed.
DIY abortion safe? No fraught with risks. Complications from Medical 4 times higher than from Surgical abortions DIY should be banned forthwith WG should publicise these risks widely to all not just women or certain target groups
Dont agree with any
Neither - it should be ended now.
Neither; stop dangerous unsupervised home abortions now.
DIY abortions should end immediately. Its risky and traumatic for women. Abortion needs medical supervision for the health and safety of women to do otherwise would be a disservice to women. The welsh government should make a public information campaign to inform all women of the risks.
The provision of abortion pills should be stopped at once.
Medical abortion by telephone should not be available. Abortion should be ended altogether. The country will benefit unquestionably.
It should end immediately. It is putting women's safety and potentially their lives at risk. Crucial medical and safeguarding steps have been removed from the process.

I believe there is a box missing above. The temporary measure of enabling home use of both pills should end immediately as the longer it continues the more women will be put at risk of physical and mental trauma. Posting medication to any woman that could seriously injure her and her wellbeing is an extremely dangerous and undesirable activity that must be discontinued.
End immediately, taking abortion pills at home without supervision is fraught with risks and complications and must be stopped immediately. The welsh government should undertake a public information campaign to inform all women of the risks they run in having an abortion.
I do not agree on this at all.
Whatever length of time is chosen , it will simply stay in force as the original Divorce Bill which was first introduced as a rare ocurrence and was then used for Birth Control.
Neither of the above, this measure should end immediately. The Welsh Government has a duty to women to disabuse them of the fallacy that abortion pills taken at home are safe. Complications after medical abortion are 13-15% more likely.
it should end immediately, The Welsh Government should undertake a public information campaign to inform all women of the risks they run in having an abortion.
Should end immediately • Taking abortion pills at home is promoted as being safe and simple, but it is fraught with risks and complications, as well as being traumatic for women. • Complications after medical abortion are four times higher than after surgical 18 – 20% compared with 5%. • Allowing women to perform their own abortions at home should be stopped immediately. • Many of the risks to women from DIY abortions are the same as with abortions carried out under medical supervision. • The Welsh Government should undertake a public information campaign to inform all women of the risks they run in having an abortion.
EMA should not be used at all.
EMA schould not be used at all.
End immediately Taking abortion pills at home is promoted as being safe and simple, but it is fraught with risks and complications, as well as being traumatic for women. • Complications after medical abortion are four times higher than after surgical 18 – 20% compared with 5%. • Allowing women to perform their own abortions at home should be stopped immediately. • Many of the risks to women from DIY abortions are the same as with abortions carried out under medical supervision. • The Welsh Government should undertake a public information campaign to inform all women of the risks they run in having an abortion.
I am adamantly pro-life and consider all life to be precious. I would like ALL abortion to be stopped
End immediately • Taking abortion pills at home is promoted as being safe and simple, but it is fraught with risks and complications, as well as being traumatic for women. • Complications after medical abortion are four times higher than after surgical 18 – 20% compared with 5%. • Allowing women to perform their own abortions at home should be stopped immediately. • Many of the risks to women from DIY abortions are the same as with abortions carried out under medical supervision. • The Welsh Government should undertake a public information campaign to inform all women of the risks they run in having an abortion.
This should, in fact, end immediately given the unmitigated problems pointed out above.
Definitely remain a permanent measure, why change a positive, successful abortion treatment process, that give women an improved independence over treatment.
For women who feel compelled for whatever reason to undergo abortion the procedure should be as quick and easy as possible since delay increases the risk to the woman
With a choice and vulnerability assessments
Become permanent as a default, except in individual cases where there are concerns.
More positive impacts from it being a permanent measure however a consultation to ensure the seriousness of the situation is understood is critical
This is being used as an emergency measure for the unprecedented circumstances we are living in.This must never become acceptable. It is dangerous and detrimental to the mother .
I do not agree with either choice and think it should be stopped immediately for the following reasons: Points to make here include: • Taking abortion pills at home is promoted as being safe and simple, but it is fraught with risks and complications, as well as being traumatic for women. • Complications after medical abortion are four times higher than after surgical 18 – 20% compared with 5%. • Many of the risks to women from abortions (under the current temporary measures) are the same as with abortions carried out under medical supervision. • The Welsh Government should undertake a public information campaign to inform all women of the risks they run in having an abortion.
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.

Become a permanent measure!
END IMMEDIATELY, before more womens' lives are harmed by an unsupervised medical procedure.
Remain unaffected
This question does not allow all possible response in the options and is therefore a leading question. I feel that the temporary measures should ensure immediately.
End immediately.
Both the above options provided (Q:8) assume that the responder agrees with one or other these options making no provision for those who oppose the present arrangement. My response is that the present arrangement allowing the home use of both 'pills' for EMA, should be stopped immediately.
The measure should be removed immediately.
It needs to end straight away. We need to show women that they are important to our society and that measures to protect and consult with them are important to us and important for their long term health and well-being. What government wants to be known for sending women pills to sort it out for themselves, as if there are matters that are so much more important for us to deal with than them.
End immediately As a minimum, the previous arrangements should be reinstated so that the various risks and safety concerns outlined above are mitigated and removed.
We need to educate our children on the moral standards which will restrict babies to properly married partners with the security of a mother and father to bring them up.
Other. I consider it negligent in any circumstance, to allow home abortions, because it puts the women at risk.
End immediately. As a minimum, the previous arrangements should be reinstated so that the various risks and safety concerns outlined above are mitigated and removed.
Stop it right away. It's dangerous. It shouldn't be happening. Women are much more likely to die as a result of this happening. As soon as you take doctors out of the equation it's bound to lead to disaster.
End immediately As a minimum, the previous arrangements should be reinstated so that the various risks and safety concerns outlined above are mitigated and removed
Ni chytunaf ag un o'r bwriadau uchod. Dylai derfynu ar unwaith. Nid yw erthyliad cartref yn ddiogel o gwbl ac nid yw'n briodol o dan unrhyw amgylchiadau. Mae'r trefniant presennol yn gosod menywod dan risg ac mae diffyg rheolaeth feddygol uniongyrchol yn gallu arwain at bob math o gymhlethdodau sy'n berygl i fywyd.
It should end immediately. Home abortion is simply unsafe and is not appropriate in any circumstances. The very nature of the current arrangement places women at risk. The removal of direct medical supervision can lead to life-threatening complications.
Dylai ddod i ben yn syth. Dyma arfer sydd yn amlwg yn beryglus ac yn hollol amhriodol dan unrhyw amgylchiadau. Golyga fod menywod mewn perygl mewn sawl ffordd.
Other. It should end immediately as it is unsafe and could lead to ladies being at risk from un-diagnosed problems that medical supervision would normally discover.
To debate the whole issue of what at present is abortion on demand .Please debate in 2021 !
The advantages noted above considerably outweigh the disadvantages, in my view.
Taking abortion pills at home is promoted as being safe and simple, but it is fraught with risks and complications, as well as being traumatic for women. • Complications after medical abortion are four times higher than after surgical 18 – 20% compared with 5%. • Allowing women to perform their own abortions at home should be stopped immediately. • Many of the risks to women from DIY abortions are the same as with abortions carried out under medical supervision. • The Welsh Government should undertake a public information campaign to inform all women of the risks they run in having an abortion. End immediately.
This ought to be cancelled forthwith. Home abortion is bound to be dangerous, even life-threatening.
End immediately. As a minimum, the previous arrangements should be reinstated so that the various risks and safety concerns outlined above are mitigated and removed.
This unsafe, ludicrous practice should end immediately. Home abortion is simply not safe and is not appropriate in any circumstances. The current arrangement places women at significant risk, flying in the face of what clinicians are supposed to be doing - caring for patients.
Home abortions are not safe under any circumstances, so should end immediately, but I could not select that as an option. It is imperative that medical assistance is close by to deal with frequent complications.
Should end immediately. As a minimum, the previous arrangements should be reinstated so that the various risks and safety concerns outlined above are mitigated and removed (answer lifted from Christian Concern's website).
Given the serious concerns highlighted regarding the safety of this measure, it should be discontinued.
It should be stopped with immediate affect.

While I can see how the temporary measure has a purpose during the Coronovirus, I believe that the risks to the health and wellbeing of women and girls will only increase the longer the temporary measure is in place and it should therefore end when the risk level due to the pandemic has been sufficiently lowered.
End immediately
It should not, in my opinion, made permanent.
I think it should be stopped immediately due to the dangers highlighted by Christian Concern
End when the temporary provision expires.
The benefits of telemedicine care have been shown therefore the temporary measure should be made permanent.
As soon as clinics are back open
stop nowpo
The temporary measure should be ended immediately. It is not in anyone's interest to continue it.
It should be revoked now.
End immediately. Re-instate previous arrangements
Other - I feel that it should stop immediately as it is unsafe and not appropriate in any circumstances
I think that these temporary measures should end immediately and all women should have access to direct medical supervision for their own wellbeing.
It should certainly not become a permanent measure but I cannot answer the second option offered here either as I think that home use of abortion pills should cease as soon as possible. Taking abortion pills at home brings serious risks and complications with it, even if it is presented as otherwise, and is traumatic for women. Unfortunately, not much seems to be done by the Welsh Government to alert women to these dangers.
End now. Clinics are open, so women should be properly assessed.
It should be stopped now.
I believe that this temporary measure should end immediately and in order to mitigate and remove the various risks and safety concerns I have mentioned above previous arrangement should be reinstated.
I feel that the temporary measure should end immediately. Home abortion is very dangerous and totally inappropriate. I believe that the current arrangement puts women at severe risk both physically and mentally and with no proper medical supervision can lead to life-threatening complications.
I believe that it should end immediately before more harm is done.
Abortion care through telemedicine is patient-centred, effective, acceptable and safe. There is no clinical, professional or ethical justification for stopping it.
Abortion should be totally decriminalised in Wales. This would then allow the use of medicines and innovations like telemedicine to be developed in accordance with best quality research and clinical need rather than in response to arbitrary laws.
Please end this immediately for all the reasons stated above.
I was never in favour of abortion in any form, temporary or otherwise.
I think that the use of both pills should be stopped immediately.
It should end immediately. It was passed without proper scrutiny and debate.
It should end immediately. Or reinstate previous risk-mitigating measures.
This should end immediately. Lives are being put at risk and they are facilitating perpetrators of various crimes and enabling them to inflict further harm on families.
Neither. It should be scrapped altogether.
The RCN support this practice becoming a permanent measure. Current arrangements (put in place due to COVID-19) should continue to enable women to proceed without an in-person appointment and take mifepristone at home, where this is clinically appropriate.
End immediately. As a minimum, the previous arrangements should be reinstated so that the various risks and safety concerns outlined above are mitigated and removed.
Should end immediately to safeguard the patients.
The practice of allowing early medical abortions at home should be stopped immediately, as the risks to women far outweigh the benefits. Her Voice encounters women every day who wish they had made another decision, and had better support, regarding their pregnancies. To expect women to carry out their own abortions at home is to neglect them. When asked about the practice of early medical terminations at home, Amy, who had an early medical abortion in hospital, said, “We shouldn’t be doing abortions. But, the psychological damage that is going to happen from dealing with that in your own home – it’s just barbaric to allow any woman to go through that.” To read all of the stories women have shared with Her Voice, visit: https://www.hervoice.org.uk/
Neither, they should not be used at all.
End immediately.
None of the above Home abortion is unsafe, is not appropriate in any circumstances and should cease immediately.
Other. It should end immediately as home abortion is unsafe as it puts women at risk and can lead to life-threatening complication.

Other-Home abortion should not be appropriate in any context. It is simply unsafe. Without substansive risk assessment, who knows what the long term outcome of even the current temporary measure may lead to (let alone a permanent implementation), on those who have had the abortion in terms of post traumatic stress, and NHS and Government liability?
The temporary measure enabling home use of both pills for EMA should end immediately. There are unaddressed safety concerns with this measure, which overwhelmingly impact already disadvantaged populations. The measures were introduced hurriedly on the back of emergency legislation from Westminster, which had not been debated in Parliament. The procedure is being promoted as safe and simple, but according to FoI responses has increased complication rates acutely, and has potentially contributed to the deaths of at least two young women, with investigations ongoing. While abortion clinics remain open, they should be required to provide full safe and effective care to their users, and to function with appropriate protective precautions in place, just as is required of all other healthcare providers.
It should end immediately. It is a total disregard of women and young girls health and well being.
I think it should be immediately stopped
Other. It should end immediately as it is unsafe, in my opinion, to continue.
It should end immediately. Home abortion is simply unsafe and is not appropriate in any circumstances. The very nature of the current arrangement places women at risk. The removal of direct medical supervision can lead to life-threatening complications.
The temporary measure should end immediately. All our answers to previous questions show that it poses unacceptable risks to women's health and wellbeing. The pandemic should not mean that good care for women is compromised.
The measure should end immediately. The risks and safety concerns already stated warrants the reinstating of the previous arrangements.
In my view it should end immediately. Home abortion is unsafe and is not appropriate. The very nature of the current arrangement places women at risk. The removal of direct medical supervision can lead to life-threatening complications.
It should end immediately, it is not safe, it places woman at risk , medical supervision should always be at hand
It is such a serious and potentially hazardous measure that it should never have been countenanced in the first place. It should end immediately.
I'm sorry, but neither is acceptable, in my opinion. This should never have been put into operation in the first place. The stable door has been opened and it will take an almighty effort by kind and compassionate people to slam it shut again!
The government should end this temporary measure immediately. The safety of women should never have been put at risk by allowing them to take abortion pills without a clinical assessment. Now that abortion clinics are open there is no reason to deny women the essential element of a clinical assessment. We were told that allowing telemedicine abortions was done as an emergency measure. It is thoroughly cynical to be moving straightaway to considering making this measure permanent. As soon as abortion clinics were allowed to open again, the government should have ended telemedicine abortions. The government should end the practice immediately.
Home abortions, with their lack of supervision should cease.
If it is working well now, why on earth go back to a more inconvenient and expensive (to all concerned) model?
It should end straight away. Women are placed at risk by the nature of the current arrangements and the removal of direct medical supervision can lead to life-threatening complications.
The temporary measure should be ended immediately. I'm quite shocked that this wasn't included in the main options. It's evidence that this consultation is heavily biased towards a particular outcome and that the dangers of home abortions are being ignored. Home abortion pills are promoted as being safe and straightforward. However there are risks and complications that women are not being told about. Nor are women told about how traumatic it can be. Women are not being told that complications after medical abortion are four times higher than after surgical abortions. The Welsh Government should ensure that the information women receive about abortions is complete, factual and balanced. This is currently not happening and the Welsh Government should address this with a public health campaign.
Domestic abuse can start with a pregnancy. Existing abuse may get worse. Abused pregnant women are at greater risk of abortion. There might be problems for hospital staff having to now post out the pills who weren't previously involved, or could conscientiously object.
These dangerous DIY home abortions should be ended immediately.
It should be ended immediately.
All home use of abortaficients should be permenantly stopped.
There is no medical reason to prevent home use of both pills, very much the reverse, and studies have now confirmed that home use is at least as safe as clinic use, and, with earlier access, safer.
It should stop permanently.
END IMMEDIATELY! Taking abortion pills at home is promoted as being safe but is fraught with risks and dangers - physical, emotional and mental.

Medical abortions are far more dangerous to women that surgical abortions. The Welsh Government needs to send out information to make the public aware of the dangers of home abortions.
End immediately. Home abortions should not be legally allowed. Monitoring for complications, detecting abuse, access to women support would be lessened. Psychological distress and trauma of seeing pregnancy being passed also needs to be taken into account. Domestic abuse could be allowed to perpetuate and the easiness of receiving the pills would normalise this procedure without fully understanding its risks.
Taking all the risks into consideration, both physically and emotionally, the decision to stop all home/any place medical abortions should be put in place immediately. The Welsh Government should, as soon as possible, publish and distribute a Report giving women all the facts especially on the carcinogenic aspect of these drugs.
The measures should end immediately. As a minimum, the previous arrangements should be reinstated so that the various risks and safety concerns outlined above are mitigated and removed.
IT SHOULD BE ENDED IMMEDIATELY - THIS IS A DAMAGING FREEDOM. The removal of direct medical supervision can lead to life-threatening complications.
It should end as soon as possible.
The practice of sending out pills for EMA should end straight away . The present arrangement puts women at risk physically and emotionally ,and without support and follow up their future mental and physical health may well be at risk .
• Any decision not to continue telemedicine would be a political decision based on a desire to restrict access to abortion, and would not be based on any scientific or medical evidence. • Mifepristone is one of the safest drugs around and there is no rationale at all for restricting it • The 10 week limit is problematic and not necessary, as has been proved in Scotland
It should absolutely be permanent. It would be discriminatory of the Welsh government not to make this a permanent measure and could cause moral injury to healthcare professionals for not being able to provide the BEST most evidence-based care to their patients.
It should end immediately. This is unsafe practice, having no direct medical supervision can lead to life threatening complications and therefore places women at risk.
Neither. These measures should be ended immediately. The risks for women are too great for the measures to be continued. To continue them, let alone make them permanent, would be a shameful abdication of responsibility by the Welsh government, whose first duty of care is for the safety and wellbeing of the citizens of Wales.
End Immediately.
End immediately. Taking abortion pills at home is promoted as being safe and simple, but it is fraught with risks and complications, as well as being extremely traumatic for women. After speaking to countless women who have had abortions, it is a disservice to offer them home abortions as a ""safe"" solution to their concerns. The Welsh Government should at the very least undertake a public information campaign to inform all women of the risks they run in having an early medical termination at home; allowing women to perform their own abortions at home should be stopped immediately as it is extremely unsafe and shows a lack of care and support for women. It is worth noting that we have used a petition against home abortion at our information stalls for the past few years since the Scottish Government announced that they would allow women to take one abortion medication (misoprostol) at home in 2017. We speak to many people with differing views on abortion, but one view that many agreed on was that home abortions are dangerous for women and should not be allowed. We received many signatures of support and many of those signatures were from those who identified as ‘pro-choice’. Only a small minority of people we spoke to in 2017, 2018 and 2019 thought this move was positive. Therefore, we concluded that the public didn’t want home use of misoprostol. If this is the case, not only should early medical terminations at home stop immediately, but so should home use of misoprostol. Since we began running public information stalls, we have had contact with and had conversations with thousands of members of the public. We often find a significant amount of the general public to be reasonably uninformed around the topic of abortion: On the law in this country – most people do not know that abortion is legal until 24 weeks gestation (or full term for suspected disability) and they are shocked by how late abortions are permitted; The procedure itself – many people do not know what the procedure itself entails and even those who have had an abortion have mentioned that they did not know it would be like that, which highlights a lack of informed consent around abortion procedures; Many do not know about the development of the baby – when they see pictures and models, even at an early gestational age, they are shocked that abortion is permitted until 24 weeks. We have found that by having these conversations with the public many who did not know much about the topic have changed their perspective on it once they have been presented with certain facts. The facts about the dangers of home abortion have not been made as clear as they should have been. This in itself is a disservice, not only to women, but to society as a whole.
It should stop at once. This is clearly an area where the risks outweigh any benefits and basic face to face contact is essential.
We recommend a reinstatement of the prior arrangements, as follows: 1. Initial telephone contact by the woman with an abortion provider to gather information about her options. The service provider can use this call to gather basic client data and to book the clinic visit. Information can be emailed to the woman after this call. 2. Clinic visit during which a counsellor discusses the woman’s presenting reasons and offers information about each of her alternatives. The counsellor should make a professional assessment of each woman’s understanding and

certainty of her decision. A clinician should complete and verify her medical history and conduct an examination including an ultrasound scan. Based on this assessment, the clinician will determine the woman's eligibility and suitability for early medical abortion at home, take her informed consent, and ask the doctor to prescribe the medications. 3. Mifepristone is administered in the clinic and the misoprostol can be taken at home or the woman can return to the clinic 2 days later depending upon her own circumstances and choice. 4. Follow-up by the abortion service provider is mandated at 2-3 weeks post the administration of the mifepristone. This could be by telephone assuming that the woman has completed a previously provided at-home pregnancy test and the test result was negative.
As a minimum, the previous arrangements should be reinstated so that the various risks and safety concerns outlined above are mitigated and removed. But ideally end immediately.
In the absence of any contraindications, i see no reason to delay this introduction.
It should end immediately. As a minimum, the previous arrangements should be reinstated so that the various risks and safety concerns outlined above are mitigated and removed.
Abortion care through telemedicine has been shown to be acceptable and safe. There is no clinical, professional or ethical justification for stopping it.
BPAS has provided more than 40,000 telemedical abortions since the home use of mifepristone approvals in March 2020. The change in regulation to enable the provision of telemedical abortion services to clients in the early stages of their pregnancy has been essential during lockdown and is necessary to provide the best possible care going forward. Based on our experience of this service, clinical evidence, and our history of providing high quality care to women, we believe that telemedical abortion is safe, effective, and makes abortion services more accessible. We support the permanent approval of mifepristone for home use across the UK.
End immediately.
DIY abortions need to end now before more psychological damage is inflicted on women
OTHER: Personally, I would like to see the temporary measure stopping forthwith and the normal doctor-patient consultation process reinstated.
Other This 'temporary' measure should never have been introduced in the first place and should cease immediately. It is unsafe on every level.
Why? So that they have a chance of returning to getting good patient cars and service from the best the NHS has to offer in best practice , not cheap expedience where there is no proper support.
END IMMEDIATELY.
I agree with neither of the available options. This unsafe practice should be stopped immediately. At the very least, the government should restore the system / provisions in effect prior to the changes made due to the Covid 19 pandemic. The risks inherent in the temporary system need to be removed at once.
Neither option
Other Home abortion should end immediately, it is unsafe in any circumstance and putting women at risk.
End immediately. As a minimum, the previous arrangements should be reinstated so that the various risks and safety concerns outlined above are mitigated and removed.
It should be ended immediately for the reasons given in answers to the earlier questions. If the temporary arrangement does become permanent, all risks mentioned above should be addressed and removed.
Home abortion should stop immediately, as it is unsafe and not appropriate, putting women at risk. Medical supervision is critical for patient safety.
End immediately. As a minimum, the previous arrangements should be reinstated so that the various risks and safety concerns outlined above are mitigated and removed.

Q9: We would like to know your views on the effects that the Termination of pregnancy arrangements in Wales would have on the Welsh language, specifically on opportunities for people to use Welsh and on treating the Welsh language no less favourably than English. What effects do you think there would be? How could positive effects be increased, or negative effects be mitigated?

Positive effects would be to offer other services as adoption either using welsh/ English, whatever that person chooses to speak.
People tend to have much better service in Wales using the Welsh language then they do using English. e.g. many utility companies have dedicated Welsh language lines that give far better customer service than English speaking customers experience if they phone the standard call centre and so I would imagine there would be positive discrimination for Welsh speakers on this subject as well.
There is no progress for the language if Welsh-speaking parents are encouraged by social pressures to kill their children. This supplements the answer on minorities above. It is far more likely that home abortion will hasten the total demise of the Welsh language as a spoken medium than that it will enhance the position of that or any other language. In order for spoken languages to survive, there must be tongues that can be taught to speak it. Home abortion is by definition totally useless for providing teachable tongues, or tongues, organs, genius brains, skilled craftsmen, of any nationality whatsoever - in fact, its purpose is to destroy any of these things before even being born into the world. The next Saunders Lewis or Leonardo seems destined to end up blocking somebody's toilet.
I believe that Welsh-speaking women who find themselves in dire circumstances due to an unplanned pregnancy should be communicated with via the Welsh language, if that is their desire.
I have never found the Welsh language to be a problem when providing Termination of Pregnancy. All women are given the choice of their chosen language.
I can't see that this affects the issue positively or negatively
None.
i do not know
Silly question. i think the the baby being terminated, or the mother under stress wound 'ant care
By doing everything at home yourself you are eliminating talking to people in any language never mind if it is English or Welsh. I am all for treating Welsh equally to English, by the way.
By all means use the Welsh language if it helps those that are considering abortion.
I have never had anyone seek a termination from me in the welsh language to date. I would be more than happy to conduct my consultation in welsh.
Allow the preferred language and treat them with dignity and respect and offer support in the right way and not abortion as the only option
This is not relevant.
Where was the Welsh version of this questionnaire?
There should not be any Termination of pregnancy arrangements whether in the Welsh or English language.
All dangers and consequences of abortion should be made abundantly clear in both languages.
Both Welsh and English should be used, if necessary in all health care provision in Wales.
I do not speak Welsh so I do not know.
no matter who you are or what language you speak the abortion is very bad for you, your body and causes long term mental health problems and scars on your personal self-esteem...
Abortion should not be used at all.
Abortion schould not be used at all.
N/a
N/A
As most written advice from the Welsh authorities are sent out in both Welsh and English I do not think there would be any effects on the Welsh language. Also most phone conversations can be held in either language
No effect in my opinion
I don't believe this would have an affect on people who speak Welsh, as long as there are Welsh speaking professionals on the phonelines for these women accessing the procedure/support.
I have no specific insights to contribute on this.
What a ridiculous irrelevant question! Women's welfare comes before the language
Ensuring telephone consultations can be held via the medium of Welsh should be part of service planning.
None.
Keep more babies alive who will be able to learn the welsh language. (Sorry that was tongue in cheek, seriously, we are talking about matters of life and death).
Personally, I think we should be able to offer all treatment leaflets in Welsh and all other languages as, in Wales we are diverse and have many ethnicities, those women miss out on a treatment leaflet unless, they have a family member who can translate for them, which they then loose their confidentiality.
The effect would only be positive - the arrangements will allow Welsh speaking women to access care in Welsh more easily, as the service would not be restricted by availability of Welsh-speaking providers in their geographical area.
No comment.
I do not see why there should be any effect.
I don't see how this is relevant. Bilingual services should be available.

I don't know, as I don't speak Welsh.
There could be more centralised Welsh language provisions via telephone. For example in Wrexham, abortion services are provided in England with no access to Welsh speakers
I believe that as long as there is equal use of both languages (any information provided in English should also have an equivalent Welsh translation) then there should be no negative effects. Treat both languages the same as they hold equal value within our country.
Minor, not an issue of concern
I don't know
There are always difficulties providing bilingual services
Unable to comment
Providing a welsh speaking service is much easier (in a centralised fashion or time clustered way) in a telemedicine provision
there should be no difference in service for welsh speaking patients or English speaking.
I'm not sure about the connection of abortion with the Welsh language. However, it would be good for Wales to demonstrate as a nation, a deeper care for women facing such a decision, by not continuing with this temporary measure but rather encouraging face-to-face engagement with those who can provide appropriate help.
Whilst I am sure that women whose first language is Welsh would prefer to speak in Welsh I would be very surprised if any woman could not speak and understand sufficient English to safely and effectively access this service. Insistence on Welsh being available is likely to cause gaps in provision or reduce opportunities for well qualified staff to work in the service because they do not speak Welsh.
Impossible to quantify impact
It will be easier for women to speak to a practitioner/consultant in their preferred language as the appointment can be much more flexible for both parties when the women are at home.
Don't know if this issue has much to do with the welsh language. I suspect if an difference access to Welsh speaking clinicians would be easier as they can work from home.
I would not know, but would assume if would remain the same or be improved as a welsh speaker could request to speak with a welsh speaking healthcare professional.
The staff providing the service is the same and so I would anticipate no effect.
-
If Welsh language instructions are provided the service is the same
If people in rural areas, who often may be Welsh speaking, can better access abortion services when they need them, then that is positive. These services should be accessible in Welsh and English either way.
Ensure equal access in languages so that no community is disadvantaged.
Don't know
No comment.
None the language spoken has no relevance to the issue of access to abortion
As a Cardiffian living in the Rhondda I dont know anyone who speaks Welsh at home and it is a shame that imposing the welsh language and duplicating everything in both Welsh and English is extremely detrimental to our future prosperity and inclusivism, costs a fortune and merely builds divisions in our United Kingdom.
No view
Not relevent to this measure there are many languages spoken in Wales now
Provided services, including advice and written correspondence, is provided in Welsh as well as English, there will be no significant impact.
-
Enabling Welsh speaking staff to provide virtual consultations where possible
I don't think that this would have any effect on the Welsh language, and is something we don't need to worry about.
Cannot Comment
Not relevant to my concerns.
We have welsh speaking staff within our team so when a patient is asked which language they prefer if they advised Welsh we would always use a Welsh speaking member of staff. If they were not available we have the option to use language line to assist is necessary. There should not be any detriment to the Welsh language in using this service.
?
So long as e-consults and telephone consultations continue to be offered in English and Welsh, this should not impact on language treatment. Patients should be offered the choice of English or Welsh consultations and be handled by the appropriate Staff member to manage.
It would be laughable, were it not so serious, to think that one is being asked to view termination of pregnancy arrangements in terms of their effects on the use of the Welsh language.
I don't have any view on the effect of this temporary measure would have on the Welsh language.
I don't know
As telemedicine care doesn’t have to be provided at a particular clinical location it should be easier to access care in Welsh or English as needed. There should not be any negative effects on the Welsh language.
No comments to make
positive for welsh language if it were stopped right now
There will be fewer people around to speak Welsh by definition.
As far as I can see, it would not affect the present situation as far as use of Welsh in the medical sphere is concerned.
I am a Welsh speaker, but I haven't seen any information on the pros/cons of abortions at home in Welsh.
I don't know.

I cannot answer this question.
I have nothing to contribute to this question.
no views
This could be better done via telemedicine - if a national welsh telemedicine abortion service could be developed, it would be easier to staff so that there were always welsh speakers available alongside english speakers. This is more difficult to ensure with face-to-face clinics.
I have made a patient care video explaining the procedure of abortion in English. Id very much like resources to also be able to provide the information video in welsh.
I am not qualified to give a view.
I think this would depend upon whether health services made Welsh speaking staff avinalble for women accessing the service.
No comment
Negative effect could be staff understanding/ability to speak welsh. More staff training could be provided or welsh language could be a requirement for a proportion of the team. Using the welsh language could discriminate people form other cultures or ethnic minority women if they are unable to speak welsh.
To ensure that Welsh is treated no less favourably than English it is important that the needs of the individual are placed at the centre of any arrangement going forward. This must include their language needs. By doing so, this will mitigate any possible negative impact and ensure Welsh is treated no less favourably than English.
No idea
I find the question crass. I am unsure as to why such consideration of the Welsh language is given in this context?
I don’t think language has anything to do with this issue!
No comment.
How does this positively or negatively affect what language people speak. Issuing abortion pills, as I have said above affects someone's mental and physical well being, as well as destroying an unborn child's life. What else matters. I am sure you provide the instructions with the pills in both English and Welsh, the outcome is still the same, a child's life is taken.
Language hardly enters into something which involves the taking of a human being’s life! We need, if you’ll excuse the pun, to “get a life” and not be side tracked by non essentials!
I don't think that there should be a difference in service provision - just as the NHS seeks to treat persons from all language backgrounds.
I can’t really comment as not a welsh speaker, but I would hope people would have the opportunity to speak to someone in their preferred language. This also of course very much applies to people from minority backgrounds for whom neither English nor Welsh is their first language.
These services should ideally be subject to and have the benefit of the Welsh language considerations that apply to other services, in particular to ensure that there is a straightforward option to access service through the medium of Welsh and that neither Welsh nor English speakers are disadvantaged.
It should not have any detrimental effect.
The Welsh language has equal status with English. Why should there be any difference in termination of pregnancy?
No impact
No particular comments on this.
No comment
Poverty can drive people towards abortion. Abortion is not a solution for poverty. All women need to have an in-clinic assessment as part of their abortion care pathway. Access is considered less important than safety.
As far as I am aware, Welsh speakers normally also speak English, and as long as information is available in both languages, e.g. online, surgeries, pharmacies and community centres, I think that use of the Welsh language is far less problematic than translation into the various languages of immigrants and asylum seekers, and ensuring the availability of information, as above. How do non English speakers access other health services?
Don't know
The positive effects could be achieved by involving political parties, such as Plaid Cymru to take a stand on women's health care issues and increase inclusivity. It can add to the language not take away from it by offering bilingual support and advice
Question not understood, but bravo for the Welsh language.
It would be necessary for some providers to be able to speak Welsh, but that is no different from existing services, and provision of Welsh speakers would be easier and more flexible with telemedicine.
I cant see any potetnial effects, there is still a consultation that takes place but remotely on the telephone or video. People have become far more used to using this as a means to communicate, ncluding in healthcare.
None
DNA
I am not a Welsh speaker so I do not feel qualified to reply.
I do not believe that this issue would affect the Welsh Language in any way.
no view
I think for both in-person and remote consultation the opportunities for people to use Welsh would depend on the availability of Welsh-speaking practitioners. It could be that a Welsh-speaker in an area where most practitioners are English-speaking could be connected with a Welsh-speaker from another area in a remote consultation.

I see no relevant connection between this procedure and the preference for use of the Welsh language.
The measure changes the default situation that abortion is illegal unless granted on medical grounds to a new situation that abortion is legal in all cases up to 10 weeks. This sleight of hand under the cover of the expediency of coronavirus is being used to achieve the complete liberalising of 1st trimester abortion. It has greater impact on Welsh children who are terminated which is far more significant the Welsh language concerns.
Positive effects: - Consultations could be provided in Welsh - Evidence and written information could be provided in Welsh - Instructions on pill packets could be provided in Welsh
It is unlikely that the majority of abortion providers supply their information in Welsh, or are able to offer prospective patients a consultation conducted in Welsh. A woman seeking help and advice about an abortion would probably have a greater chance of being able to discuss the matter in Welsh by attending a local clinic than by obtaining pills from a remote provider.
No effect comes to mind. It is possible that a Welsh-speaking woman may only have access to an English-speaking abortion provider on a telephone conversation but this could also happen in face to face consultations. On a clinic visit, however, there may be a greater likelihood of finding another person close at hand with Welsh-speaking ability.
I'm not going to answer that question because I believe it to be irrelevant and actually insensitive, to consider this to be an issue when the consultation effects the very lives of women and children.
We do not believe the termination of pregnancy arrangements will have any impact positive or negative on the opportunities for people to use the Welsh language.
There should be a positive effect as more welsh speaking health care workers are available for consultation over a wider area of the country, rather than restricted to a physical area of work.
I'm not sure.
I think this is not an important concern in this context and i say this as a Welsh speaker/learner.
Would the telephone service and e consultation have the opportunity to be answered in Welsh? Are all information provided in Welsh aswell as English including instructions, side effects, future care,and what to expect?
The use of telemedicine in abortion provision has the potential to improve Welsh language arrangements in such care. Accessing care by telephone/video call means that the patient can be connected to a central call centre. It is far easier for a central call centre to have a Welsh speaker available at all times than it is for each individual physical clinic to. To prevent English being favoured, a simple pre-recorded menu could be used to select a language, meaning those who wish to speak in Welsh can be immediately put through to a Welsh speaker rather than having to request this in English first.
Welsh language availability is key to provision within Wales, both in the NHS and in commissioned services such as BPAS. We do not believe there is any impact on the Welsh language of telemedical abortion care. As a service, BPAS provides abortion information and clinical care in Welsh where requested. However, not all of our staff members speak Welsh. The provision of telemedical care enables us and other providers to book appointments specifically with Welsh-speaking staff if requested by clients, whereas in-person care relies on staff availability and potentially increased waits for Welsh-speaking staff to become available. Telemedical abortion care is provided by the same staff as in-person care throughout Wales, so in and of itself, there will be no impact of this change on the availability of care in Welsh.
No effect. The women will have the same discussions with the same clinicians. Just remotely rather than in the clinic.
that is up to the implementers to ensure service meets local needs- I see no reason why it should be detrimental
Since many people in Wales will travel to England to access abortion because the clinic is closer, it could be that a telemedical service might better enable opportunities for people to be consulted in Welsh (by another native speaker) or to be assisted by a translator.
Effective communication is essential but developing a positive alliance with the patient may or may not be hindered with the clinician using welsh or English.
Probably there would be a return to old wives tales as there is an apparent shortage of sufficiently fluent Welsh speakers to advise and give proper advice on consultation across N Wales
Not relevant to the situation.
Not being Welsh or a resident of Wales, I am unable to answer this question.
I don't think it would have any effect.
No direct view on this, But the lack of personal consultation will inevitable result in less opportunity for using the Welsh language.
None.
Language is not relevant as Welsh people speak English.
Don't know
Talking and consulting about a topic as life-altering as an abortion requires the pregnant woman to have the capacity to fully express her feelings, concerns and to ask any questions she may have. This would not be possible for a woman whose first language in Welsh and who may find expressing herself through English more constrictive. If the supervision and consultation was only available in English, first language welsh speaking women would not have the same level of confidence discussing sensitive and personal issues. To not have the same level of communication in Welsh than what is available in English, would risk placing a higher priority on convenience than the comfort and wellbeing of first language Welsh women.
Use of the Welsh language is very important but can't see how this is an issue here.

I dont know if the instructions for use of the Drugs used are available in both languages or if this is necessary. If women choose to have their in person consultation in their preferred language this should be accessible
Let me be clear: I am an incomer to Wales. I love the area where I live, I love the people where I live and with whom I work. As a key worker, I serve Welsh people. I am a Welsh learner, and use the language, in my limited capacity, on a daily basis. But this issue is not about language: this is life. A Welsh babi being aborted is as sad and tragic as an English or Scottish baby. I have taken part in fund raising events for special care baby units in my area for people who have used neonatal intensive care to save tiny babies who in other circumstances could have been aborted. Their only deciding factor was who conceived them as to their appearance or not in this world. I feel very strongly that a child cannot choose who he/she is born to, but adults should make responsible decisions in their relationships. Abortion is not a responsible decision.
It could be beneficial to the use of the Welsh language
This would depend upon how much providers of such services provide bilingual services.
None at all!
Unfortunately, I have no knowledge on this point,
I don't know.

Q10: Please also explain how you believe the proposed arrangements could be formulated or changed so as to have positive effects or increased positive effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language, and no adverse effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language.

Treat all as equal on whatever that person wants to speak and explain everything.
Have the same ratio of advisors to callers in either language.
They can't be - see above.
Rydw i wedi dweud o'r blaen bydda 'r awdurdodau iechyd yng Nghymru cyfathrebu gyda menywod beichiog mewn iaith Cymraeg, os mae hynnu 'n ddymunol iddyn nhw.
Again, I have never found an issue.
As Q 9
The ordinary arrangements should cover this eventuality as with others. That is the whole idea of having suitable 'ordinary arrangements.'
i do not believe they can be
I am not sure this has any relevance to the subject we are discussing!
As I stated treat everyone with respect and support them in their situation so that they can do the right thing morally like choosing adoption over abortion
Money should not be wasted to translate the proposed arrangements into the Welsh language.
Abortion should be ended in Wales and the UK so funding in Welsh-language and culture can be spent more wisely and other other more positive things.
Both Welsh and English should be used, if necessary in all health care provision in Wales.
Again , I cannot say
no matter who you are or what language you speak the abortion is very bad for you, your body and causes long term mental health problems and scars on your personal self-esteem...
Abortion is nothing positive.
Abortion is nothing positive.
N/a
N/A
The only problem I can foresee is that instructions for how and when the tablets are to be taken will have to be translated and there is a possibility for mistakes.
Not applicable
Ensuring there are people available in the health service who speak Welsh.
See previous question.
See previous answer
Employ only welsh speakers to provide abortion services.
I am more than happy to offer translation if a woman would like to use welsh language. We have facilities in clinic such as interpreter on wheels.
?!
Adopt a whole-Wales approach; abortion care would be provided by all health boards, to all health boards, so as to ensure sufficient Welsh language coverage using telephone or virtual consultations, so local area is not a restriction.
No comment.
Again, I do not see why there should be any effect so I do not believe that any change is necessary
Employ equal Welsh speakers and English speakers and offer choice.
I don't know, as I don't speak Welsh.
I believe that the arrangements should have no impact on the use of the Welsh language, those who wish to communicate in the Welsh language should be given the opportunity to do so, for example with their doctors or through websites and the deliveries to home that contain the pills should all contain both English and Welsh translations of the details contained within such as the correct way to carry out the procedure, risks and any other information provided.
See above
Unable to comment
A proposal could contain the use of pre consultation e-forms that coul dbe available in both languages and which woul d give women the choice of requesting a welsh video consultation subject to availability.
This highly P C question sounds like Civil service gobbledegook! It is certainly murdering the English language.
Unable to comment
As above
Thus is entirely dependent on number of Welsh speaking clinicans. I do not know how to achieve this unless there are more Welsh speakers working in abortion services.
-
Welsh speakers employed to give advice and counselling if required would provide a service equal to an English one.
I speak Welsh as a first language and live in rural Wales and I, and any other people like me, should be able to access health services like this and like mental health services and any other services equally to everybody else. I

don't see how it'd affect the Welsh language particularly, other than of course all of these vital services should be available in Welsh and English.
Language should be assessed at early access and options for care offered equally.
Don't know
No comment.
in 2021 we would be far better off using the language of the whole of the UK rather than create diversity and nationalism in a country where everyone can speak English and by insisting on the use of Welsh is simply backward looking, imposes severe limitations on both staff recruitment, and encourages the brightest and best of the rest of the UK to move homes and businesses away from Wales.
No view
To continue this temporary provision of unobserved home abortion is wrong .
See previous answer.
-
Na
My answer to question 9 applies here.
Cannot Comment
Not relevant to my concerns.
See above
?
A tick box system on e-consults and a telephone option for the Welsh or English language option should be provided, giving service users the option of either language. All information, assessments and leaflets can then be provided in the service users preferred language.
See above (Q9).
N/A
I don't know
There should be no adverse effects on opportunities for people to choose Welsh language consultations.
No comments to make
must be stopped now for good effects on all sections of welsh population
People should be given the choice of Welsh or English. This could be done (as it already is in a number of places, e.g. DVLA) via an automatic telephone message the other end of the line first and then a Welsh speaker to deal with the issue.
n/a

I have nothing to contribute to this question.
no views
This could be better done via telemedicine - if a national welsh telemedicine abortion service could be developed, it would be easier to staff so that there were always welsh speakers available alongside english speakers. This is more difficult to ensure with face-to-face clinics.
Resources need to be available in both Welsh and English
I am not qualified to give a view.
The Welsh government could require the services of a Welsh speaking professional team to be available to all women and make this known publicly using all forms of media
No comment
Offering both welsh and English information could be an option and a personal choice of the woman under going the EMA.
Any proposed arrangements must be formatted with the needs of the individual at its heart. This must include their language needs. If an individual would prefer to have a virtual consultation in Welsh there should be staff available to facilitate this, without a delay. To ensure there are enough staff to deliver services in Welsh their ability to speak Welsh needs to be recorded. The Electronic Staff Record (ESR) records individual's ability to speak Welsh. However, it is not a mandatory field and therefore information can be inconsistent. To ensure information is accurate, any field that can record the ability to communicate in Welsh must be standardised and made a mandatory field. This will allow NHS Wales the ability to meet the needs of the population through ensuring a bilingual workforce is available. This would ensure Welsh is treated no less favourably than English. Furthermore to ensure that NHS Wales can continue to provide bilingual services, the NHS Wales Active Offer scheme must continue in online settings as well as face to face. The Active Offer scheme simply means a service can be provided in Welsh without someone having to ask for it. This takes the pressure off the service user to ask for a service to be provided in Welsh. The positive impact from the Active Offer scheme is clear and will aid in the culture change to ensure the Welsh language is as visible as the English language.
No idea
N/A
No comment.
I think my last answer will suffice to answer that.
If services have provision for translation whether over the phone, or seek to employ persons speaking Welsh language this should help those who speak mainly Welsh. Similar is of course true of any persons of whom English is not thier first language.
Don't know enough to comment on this.

By treating both languages equally, as required by law.
No particular comments on this.
No comment
The practice should end immediately. It should never have happened. It came in with no parliamentary scrutiny. Women are not being well served by this. Clinics are open again. This is a cynical thing having been told this was a temporary, emergency measure.
I am a non Welsh speaker who supports the rights of Welsh speakers to use their language. However, in large parts of Wales English is generally used as the working language, which I feel is unlikely to change.
Don't know
By offering the tele consultations in Welsh as well as English to reflect the diversity of the country and especially in northern areas where Welsh is more likely to be spoken
Everything should be done to preserve and promote the Welsh Language.
The flexibility of telemedicine provision would make the use of the Welsh language easier to provide.
There should always be an option given at booking appointment to use Welsh or English language.
None
DNA
See above.
no comment
That flexible arrangements are made to be able to connect people to a Welsh-speaking practitioner, if necessary from another area.
In English or Welsh, the message to women should be to discourage the aborting of the unborn
- People who only speak Welsh could ensure they speak to a Welsh-speaking healthcare professional which is easier managed over the telephone than in an in-clinic consultation where the professionals may not speak Welsh and may not be able to cater for such people.
No measures that would be likely to be helpful come to mind.
n/a
We do not believe the termination of pregnancy arrangements will have any impact positive or negative on the opportunities for people to use the Welsh language.
no comments
Not sure.
See response to previous question.
Abortion care is an NHS service, and as such should be treated no differently to other healthcare when considering the effects of the Welsh language.
See answer to question 9
sorry- this convoluted question is beyond me to answer. Welsh or punjabi or polish or any language should be capable of being positively managed
Offer the patient the choice of welsh or English speaking therapist
Ther should always be available qualified Welsh speaking counsellors and NHS practitioners to discuss their situation and needs with patients for whom Welsh is their first language
Language is not relevant to this very important issue.
Not being Welsh or a resident of Wales, I am unable to answer this question.
Keeping the pre-covid arangements would allow patients access to Welsh-speaking medical services as were already in place.
Can't comment on this in detail. But face to face consultation is invariably more effective when using a language that could be the second language for either party in the conversation. So return to face to face consultation will be the best outcome for use of the Welsh language
None.
See Q9
Don't know
The effect of having an abortion can make the woman feel incredibly lonely and isolated. The current legislation doesn't do enough to help women process these life-altering feelings, with telemedicine being a considerably poorer alternative to proper supervision and in person consultation. Woman therefore need proper supervision, consultation, and counselling in order to properly provide care through an abortion, and furthermore it is essential every part of this process is offered in Welsh, so they can properly express themselves and feel valued.
Use of the Welsh language should be encouraged where possible for those to whom it is important.
I fully support the use of the Welsh language as the foremost language of Wales. I believe signage should be primarily in Welsh. Welsh is the mother tongue and heartbeat of the Welsh people, even those who live outside of the nation. In fact, in such cases, even more so. I believe that counseling services should be available via the medium of Welsh, so this would mean investment to train people to promote other options, such as adoption and other supportive strategies, rather than just leaflets in a literature stand in Welsh, promoting abortion.
Unable to comment further
This is not relevant to this consultation.
As above Q9
I don't know.

Q11: We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:

God will judge us on our actions. Life is precious from the moment of conception!
One trouble with home abortion - any abortion - is that it involves people in their daily work in a number of demeaning and personally degrading activities. People are asked to retreat into denial - calling the dismemberment or poisoning of pre-birth human beings by a different name - not admitting to any problems involved. In the personal sphere, I have found this to be the case with candidates for political office, who consistently fail to respond to direct questions concerning their attitude to abortion. In the case of the present Pontypridd MP she left it 5 months before admitting that she was pro-abortion, apparently of the most glib and unreflecting kind. A series of submissions to my 5 members of Senedd produced the same total inability to indulge in dialogue, or proudly state, and for good reasons, why they approve of abortion. This is a symptom of the general unwillingness to tackle such questions openly. If abortion, as suggested by the general tenor of this questionnaire, is such a wonderful facility for the women of Wales, why have 6 political representatives of different political persuasions been unable to tell me so? Others in other fields, we are sure, are suffering from the same guilt-ridden silence. The other big, big objection to home abortion is the effect it has on the poor woman or girl undergoing the operation. ""I was in such pain,"" said one, ""I thought I was about to die."" You can't simply ignore the effects of post-abortion syndrome, or pretend it doesn't happen. The only certain cure for that cocktail of emotions and conditions is not to have that abortion in the first place. Energies and public monies could more compassionately be expended in finding a home for babies that remained unwanted after a natural birth. I also object to the fatuousness of another so-called ""Consultation"" which the powers that be may simply ignore, like a previous one. The questions presuppose that the absolute despair and horror of a self-inflicted abortion is somehow a good thing. It isn't. It's a symptom of absolute social failing, and of the treatment of women as so many stupid cattle unworthy of honour or respect or public help. A truly civilised society would set its sights on the disappearance of abortion altogether: even those who reluctantly accepted it would some decades back claim that that was their ultimate aim. It is obvious from the figures that that aim is no longer being pursued: rather, that killing pre-birth babies has now become a good in its own right. At least one Welsh citizen wishes to express his dissent from this dire and despairing philosophy.
Triaging women before their appointment has drastically reduced the time spent in clinic.
Attitudes have altered over the years. Certainly a medical method of inducing an early termination is preferable, if you have to; but proper instruction in birth control to everyone - at school, for choice - is essential. This applies to boys as well as girls. The ignorance of children about what happens when you grow up used to be dreadful. I was chairman of governors in a comprehensive school and we had little study groups for the children, but it still didn't stop the occasional mistakes.
Yes, Make sure that this consultation is taken notice of and conveyed to 'all Assembly Members (whether for or against DIY abortions). and the out come of this consultation not just a public relations exercise.
I think I have made this clear above.
This should not even be a choice or be on the proposed agenda, it is wrong and always will be. God gives life and God takes it away and that's it in a nutshell
What the Welsh Government is trying to do is morally repugnant and should be stopped.
Legislation aside, abortion is a moral stain on the modern world. We shouldn’t be making it ever easier to perform. I accept that we live in a world where it is accepted but I don’t think we should give carte blanch to an ever pressing lobby to make it more and more available. It is a huge decision which affects the family and kills a perfectly viable person. The very least we could do is provide women with meaningful and genuine consultation over the procedure. Not just a bag of a pills and leave them to it.
I trained as a nurse so am aware of the distress the effects of abortion have on all women. I myself underwent a termination when at 20 weeks it was discovered that the baby I was carrying had no chance of surviving outside the womb. Even though I knew this was not the wrong thing to do and two consultant obstetricians advised me that it was the right course of action it was an extremely distressing event and I can put my hand on my heart and say that I know it was the cause of about 20 years of deep depression. Supplying DIY abortion to women without consultation is dangerous and reckless and the repercussions will most surely be felt long after the Covid Pandemic is a thing of the past.
What encouragement or advice from our government/NHS for those during these troubled time who don't want and Abortion ?..helplines etc.
I find that no matter how many voices are raised against various laws they are steamrollered through without any or very little condsideration for those with opposite views.
I am concerned about the use of telephone consultation as this is not a safe or secure way of accessing the clients vulnerability. To ensure good safeguarding a women must have freedom of choice and a telephone consultation cannot establish this. There may be another person present unseen in the room who is coercing the women and even instigated the procedure.
I am pro life and against abortion.
I am pro life and against abortion.

I just feel that this is a convenient measure to solve an 'inconvenient problem'. It is intensely impersonal and removes the medical practitioner one step further away from the responsibility of ending a life.
I can not understand why consultation asks about influence on welsh language while WG has not asked about influence on welsh nation demographics, mental health, physical health etc. Have you not identified any risks associated with making this provision permanent?
None.
It's about time people's health and education came before the language yes it's important but not to the detriment of everything else!
We now live in a world of technology and women/girls are very au fait with abortion treatment, most are fully aware of the changes of two pills at home. Most women comment and are relieved they can have the two pills at home. Staff and women have adapted to theses changes dramatically in a positive way.
Telemedicine provides accessible, safe, and effective abortion care – enabling women to make the right choice for them. • Waiting times are shorter, gestations are lower, and services have greater capacity • It is supported by clinicians, regulators, providers, and women. Of clients who received Pills by Post who expressed a preference in follow-up surveys, more than 80% would choose the same method again. • Abortion care should be evidence-based and reflect the best possible care available to women. Telemedicine is key to providing up to date, high quality care going forward.
I am concerned especially that young or very young women, whose whole future lives would be affected by an unwanted pregnancy, should be free to make their own decisions, and the less cumbersome the procedure the better that would be.
N/A
The continuation of tele medicine in abortion care should ideally be complimented by pharmacy provision of contraception under a national PGD to maintain the advantages gained through increased confidentiality and convenience and to reduce geographically cause disadvantages further in a way that means women may be able to avoid conception in the first place.
1. Post COVID, the option of in-person appointments should be clearly offered as an alternative to telemedicine, in addition to those cases where medical history or safeguarding would require an in-person appointment. 2. There should be statutory changes made as soon as possible to ensure there is a routine follow up appointment within one month of the abortion with a requirement that providers must then update the details already provided to the Chief Medical Officer on the date that the pills were taken and that either the woman reports no complications, or, give details of complications experienced. 3. There should be immediate actions to ensure there are formal pathways with hospital/clinics who could see patients with complications (such as emergency departments, gynaecological services and Early Pregnancy Assessment Units) so that they can input to the notification system if they treat patients following or during medical abortion. It is important that a broader spectrum of outcomes can be tracked to maintain safety standards, not just the most serious complications. This is necessary to provide a clearer picture of what complications and experiences women are facing to inform decision making. 4. In view of the early evidence suggesting an increased risk of ruptured ectopic pregnancies in medical centres in other countries, we also recommend that research is conducted in Wales (perhaps with England) as a matter of urgency to determine whether any similar trends have been documented and whether these are cases linked to terminations or otherwise and to determine what mitigating action can be taken if an increase is found.
No comment
Termination is not just a medical procedure, we need to have services in place to support individuals who suffer trauma following their termination decision - this may not even surface until many years later. We also need to ensure that women are aware of the choices available to them and provide credible alternatives to termination.
Is this service vital as go appointments become as rare as hen's teeth? Impact on wider local health clinics. Impact on teenage users access?
As a Christian I believe every life is sacred and of value and abortion is the deliberate killing of a growing baby. Crisis is not ended by abortion. Many women suffer physical and emotional harm after and BMA studies show that abortion causes women to have miscarriages. Many suffer in silence. Women deserve better. Many years ago I supported a friend in having an abortion and very much regret it. She needed support and encouragement to have her baby which I couldn't offer.
-
None
None.
Byddai'n gwneud bywyd llawer haws i nifer fawr o bobl petai'r polisi presennol i alluogi pobl feichiog y gymryd y ddwy bilsen adref barhau.
Termination of pregnancy,at any stage after conception is an act of killing .Legalisation does not alter this fact ,however unpalatable the truth may be. There are alternatives to abortion.There are organisations providing help and support for women with unwanted pregnancies.Termination of pregnancy is not the caring and helping action it is promoted to be especially as promoted by the Welsh Government at this time, for the reasons stated.
Life is a gift. It is a gift that only women are biologically capable of perpetuating through the sacrifice of so much of themselves through pregnancy. Let's honour their sacrifices and listen to them. Allow them to see how society values them enough to talk to them in person. Thank you.

Allowing women to perform their own abortions at home should end immediately – this policy was never brought in with the intention of making it permanent, the government had promised it was purely a lockdown measure. Clinics are now open again, so women can go in to get the proper assessment. All women need to have an in-clinic assessment as part of their abortion care pathway. Taking abortion pills at home is promoted as being safe and simple, but it is fraught with risks and complications, as well as being traumatic for women. The government should undertake a public information campaign to inform all women of the risks they run in having an abortion.
Pregnant women should be allowed the opportunity to see that their pregnancy is a human life. It is right that pregnant women know that the life inside them is not merely a clump of cells, in the same way that adult human beings are not merely clumps of cells. Women should be told basic facts about their unborn babies. For example, the heart starts pumping blood from five weeks, and from week nine fingerprints are evident.
Women do need to be respected and told the facts about their unborn child, including facts like, at 4 weeks the heart and blood vessels are developing, at 5 weeks the heart is pumping, and at 8 weeks the arms and legs are well formed. This means they are fully aware that their pregnancy is a human life.. Abortion is never the answer as it so often leads to lasting sadness at taking the life of their unborn child.
Allowing women to perform their own abortions at home should end immediately – this policy was never brought in with the intention of making it permanent, the government had promised it was purely a lockdown measure. Clinics are now open again, so women can go in to get the proper assessment. All women need to have an in-clinic assessment as part of their abortion care pathway. Taking abortion pills at home is promoted as being safe and simple, but it is fraught with risks and complications, as well as being traumatic for women. The government should undertake a public information campaign to inform all women of the risks they run in having an abortion.
The main thing for myself and countless other Christians all over the UK is that we'd love to see women given the privilege of seeing that these aren't just ""pregnancies"" but rather the holding of human lives in their wombs. We could start by at the very least encouraging women to see that there are things about unborn babies that everyone needs to know. Stuff about how the brain, spinal cord, and parts of the central nervous system are well formed by just month two! Does this not make us think twice about taking a quick pill? We want human life to be seen as precious, and for people to see that abortion is never a solution to problems, and only the cause of many more problems.
Allowing women to perform their own abortions at home should end immediately – this policy was never brought in with the intention of making it permanent, the government had promised it was purely a lockdown measure. Clinics are now open again, so women can go in to get the proper assessment. All women need to have an in-clinic assessment as part of their abortion care pathway. Taking abortion pills at home is promoted as being safe and simple, but it is fraught with risks and complications, as well as being traumatic for women. The government should undertake a public information campaign to inform all women of the risks they run in having an abortion
Mae'n hollbwysig fod menywod beichiog yn cael y cyfle i weld bod bywyd dynol yn eu dwylo pan ydynt yn feichiog. Mae'n gwbl gywir a moesol iddynt ddeall mai bywyd sydd y tu mewn iddynt ac nid dim ond casgliad o gelloedd. Ni all ddosbarthu tabledi erthylu yn y modd a gymhellir ond cadw nifer y erthyliadau yn ein gwlad yn uchel, a lleihau gwerth bywyd dynol.
Making abortion pills so easily available will inevitably contribute to keeping the numbers of abortions high, and cheapen the value of human life.
Dylid rhoi'r cyfle i fenywod beichiog weld nad yw ffetws yn fwy o glwstwr o gelloedd nag y mae oedolyn. Bywyd dynol sydd yn tyfu ynddynt ac fel rhan o'u gofal meddygol, dylent gael y cyfle i ddysgu gwybodaeth sylfaenol am y baban, er enghraifft, bod ei galon yn pwmpio gwaed ar ôl pum wythnos neu y gellir gweld olion ei fysedd o'r nawfed wythnos ymlaen. Bydd gwneud mynediad at gyffuriau erthylu mor hawdd yn arwain at israddio gwerth bywyd dynol, yn enwedig bywydau rhai grwpiau penodol, er enghraifft, y rhai ag anabledd. Nid yw'n iawn rhoi terfyn ar fywyd baban er mwyn ceisio datrys problemau a achoswyd gan bobl eraill.
Making abortion pills so easily available will inevitably contribute to keeping the numbers of abortions high, and cheapen the value of human life. The British Parliament have now killed more British children children than the number of Jews killed by Adolf Hitler. 8,000,000 compared to 6,000,000.
I feel that making abortion just another form of contraception will only help to cheapen human life, and for the disadvantaged unhelpful. Ladies should be told that inside of them is human life not just a clump of growing cells, much li8ke adults and children are not just a clump of cells either. To me human life is important and a human being does not just become one at birth.
N/A
To make it easy for women to have abortions is bound to cheapen the value of human life, and many women have already regretted killing their own unborn baby.
Allowing women to perform their own abortions at home should end immediately – this policy was never brought in with the intention of making it permanent, the government had promised it was purely a lockdown measure.

Clinics are now open again, so women can go in to get the proper assessment. All women need to have an in-clinic assessment as part of their abortion care pathway. Taking abortion pills at home is promoted as being safe and simple, but it is fraught with risks and complications, as well as being traumatic for women. The government should undertake a public information campaign to inform all women of the risks they run in having an abortion.
Making abortion pills so easily available will inevitably contribute to keeping the numbers of abortions high, and cheapen the value of human life. If we have learnt anything in the past year it is that human life can so easily be snatched away. We must value human life, as I'm sure the grieving 100, 000 families who have lost loved ones to covid-19, would agree.
The ease of receiving two pills in the post to end a pregnancy trivialises abortions. It reduces it to the level of taking a couple of paracetamol pills to terminate a headache. In reality it is a life-changing decision that can have very serious repercussions on a women's physical and mental health. It is important that women have the opportunity to be properly appraised of the reality of the life inside them being not just a clump of cells. Abortion is never the right solution. Even in more extreme cases, such as rape, women often deeply regret their decision to take the life of their unborn baby. In many ways the premise of this question and consultation is fundamentally wrong. Abortion always involved the killing of a human baby, and can often have serious consequences on the mother's health. The Abortion Act should itself be repealed.
The government promised that this policy was only a temporary measure - it should honour those words and end it immediately, now that clinics are open again.
Woman should be informed about the emotional distress and increased risk of mental health issues (Coleman, PK 'Abortion and mental health: quantitative synthesis and analysis of research published 1995-2009, British journal of psychiatry, 199 (3) 2011, 180-186) with abortion at the time of consultation with a clinicians. This is important for fully informed consent.
The introduction of the temporary provision of DIY abortions under the guise of the Covid pandemic was a grievous move - surreptitiously and hurriedly brought in and speciously justified in terms of the emergency situation arising from the pandemic. Many of us feared that this temporary arrangement would inevitably be made permanent, despite assurances to the contrary. I sincerely hope and pray that it will not. The abortion lobby have had many triumphs in recent decades, but even they could hardly have expected so easy a ride in so vitally important a matter.
How are we so insensitive to the violent destruction of human life, there is something radically wrong! As society have embraced evil as good. Do the right thing and reject this measure. You will be held to account
Please access Christian Concern's investigation, it is horrifying how these pills have just been handed out without proper counselling and follow up.
It is often difficult in a pregnancy to be accurate about dates and times. It had been established that a very young foetus, even less than ten weeks can feel pain. There needs to be more scrutiny from parliament on this and more input from health professionals.
the whole concept of abortion is wrong - it is killing a new human being made exclusively in GOD's image
This temporary policy was not brought in with the intention of making it permanent. The government promised that it would finish after lockdown, and so it must. Home abortions are by no means risk-free, and promoting them as safe and easy is entirely wrong.
This whole attitude towards human life is a disaster for society.
Clinic are open again now. All DIY abortions should cease immediately Taking abortion pills at home.is not safe. The Government should give women the full facts concerning abortion. When women are given the full facts they often decline abortion.
Making abortion pills so easily available will contribute to keeping the number of abortions high and cheapen the value of human life.
I think that the implications of having an abortion should be clearly laid out for anyone asking for it. The baby in the womb is not just a group of cells, but another human life - perhaps the physical stage of the baby could be explained eg the heart pumping blood, the fingerprints being evident etc. even at a very early stage. The impact of abortion on the woman can be felt many years after the event, even after a traumatic event such as rape, there may be regret in the future. Though these drugs may be safe in many cases, there may well be unforeseen complications and great danger to the woman without direct medical supervision.
Regarding Welsh, it's a pity that there was not a Welsh version available of this questionnaire. Any particular reason? It would have been easy to arrange a translation, and for many of us it would have made a better impression as being more inclusive.
This policy was announced by Health Minister Vaughan Gething as a temporary measure. It should end straight away, so that women are assessed properly as clinics have reopened. This will be safer, e.g. to prevent women who are >10 weeks gestation from having these home abortions.
Killing babies is absolutely wrong, like any other wanton murder. This practice is encouraging it even more.

Allowing women to perform their own abortions at home should end immediately – this policy was never brought in with the intention of making it permanent, the government had promised it was purely a lockdown measure. Clinics are now open again, so women can go in to get the proper assessment. All women need to have an in-clinic assessment as part of their abortion care pathway. Taking abortion pills at home is promoted as being safe and simple, but it is fraught with risks and complications, as well as being traumatic for women. The government should undertake a public information campaign to inform all women of the risks they run in having an abortion.
As abortion clinics are now open again enabling women to get a proper assessment and examination I believe the current arrangements of allowing women to perform their own abortions at home should terminate without delay. This policy was brought in purely as a lockdown measure and the government has assured the public that it is temporary. Using this as a back door to bring about a permanent change in procedure can only increase mistrust in the government.
Many people do not know how quickly the baby develops, for example the baby's heart is pumping blood from 5 weeks. The baby is not just a clump of cells but a living being and often once women have seen their baby on a scan they will not wish to lose that baby. and so not spend the rest of their life regretting such a decision. Making abortion so easy continues to cheapen the value of human life. An unborn baby is still a human being.
It may seem on the surface to be a quicker, easier solution for women seeking terminations, but I think this is an issue of real concern, as this is a huge decision and needs as much support around it as possible, as making it too ""easy"" could in fact lead to an increase in mental health consequences both from the practical and in some cases distressing outworking of the procedure at home, and also in inadequate less personal assessment regarding the safety of the actual decision. There is also the risk that the medication could be procured by one person but actually administered to a different person, possibly against their will.
Killing a child should surely not be the answer to any problem.
Allowing women to perform their own abortions at home should end immediately. As clinics are now open again, women can get a proper assessment. Women need an in-clinic assessment as part of their abortion care pathway. The government had promised that the policy it was purely a lockdown measure and never intended to be permanent.
Providers are still heavily reliant on doctors to run abortion services when this is not necessary and could easily become nurse led. The time for decriminalization is now
The home abortion measure was only supposed to be temporary due to COVID lockdown. If clinics are open it should be discontinued. There is no excuse.
There has been no discussion regarding the opportunity for the women to have a choice about where the EMA takes place. I think it is important to discuss both onions with the woman and after a holistic assessment has been done, considerations should be made as to which option is safest for the woman.
I feel a lot of emphasis is put on women and them having control over their bodies, as a woman I understand this perspective but I think this argument ignores the right of the unborn child. Whilst we focus on the rights of the woman, we neglect to talk about difficult issues such as the baby's development in the womb and what abortion actually is - the taking of a life. In order for us to really support the rights of the woman (and child) then all the information about abortion needs to be known, not just the "palpable" aspects.
Pregnant women should be allowed the opportunity to see that their pregnancy is a human life. It is right that pregnant women know that the life inside them is not merely an agglomeration of cells, in the same way that adult human beings are not merely agglomerations of cells. Women should be told basic facts about their unborn babies.
The temporary changes in the current law allowing home provision of both pills for early medical abortion should become permanent as the option of provision of treatment at home is shown to be safe, effective and efficient. Women also need to be given the choice of accessing such care in their home or a clinic. This will make good use of the skills and expertise of nurses and midwives and represents greater equality and accessibility for women. The RCN has provided evidence on the current arrangements for the termination of pregnancy to the Scottish, English, and Welsh Governments. This consultation response represents the RCN's four-nation approach to the termination of pregnancy but has been tailored to the specific context of Wales and reflects the views of RCN Wales.
Allowing women to perform their own abortions at home should end immediately – this policy was never brought in with the intention of making it permanent, the government had promised it was purely a lockdown measure. Clinics are now open again, so women can go in to get the proper assessment. All women need to have an in-clinic assessment as part of their abortion care pathway. Taking abortion pills at home is promoted as being safe and simple, but it is fraught with risks and complications, as well as being traumatic for women. The government should undertake a public information campaign to inform all women of the risks they run in having an abortion.
By using this method the number of abortions is quite likely to increase where as I believe patients should be informed of any alternatives and possible effects on their future mental health
Allowing women to perform their own abortions at home should end immediately. This policy was never brought in with the intention of making it permanent. The government promised it was only a lockdown measure. Clinics are now open again so women can get a proper assessment. All women need an in-clinic assessment as part or their care pathway. Taking abortion pills at home is promoted as being safe and simple but it is fraught with risks and complications as

well as being traumatic. The government should undertake a public information campaign to informal women of the risks they run in having an abortion.
A pregnant woman should be given the opportunity to see that she is carrying in her womb a human being, not just a mass of cells. This should not be seen any differently to the fact that an adult human being is not merely a mass of cells. Women should be told facts such as that the heart begins pumping blood from five weeks gestation and by week nine fingerprints are evident. Easy availability of abortion pills will lead to more abortions and thus cheapen the value of human life in the eyes of people.
Making abortion pills so easily obtained cheapens the value of human life.
Easy access to home abortion pills will inevitably lead to more abortions, cheapening the value of human life. Women should be given more objective facts about the life and development of their unborn child and counselling before making such an important decision.
1. I am concerned that this document, which is supposed to be about consultation, is couched throughout in terms that suggest only benefits from the 'temporary measure' introduced in response to the COVID pandemic. This could be construed as a deliberate attempt to discourage anyone with different views from responding. 2. Clients provided with both pills for home use without thorough clinical assessment are receiving a lower standard of care than would normally be available to them. Ease of access should not be allowed to trump safety considerations. If there are difficulties accessing a clinic for appropriate care, then this should be the focus of concern, rather than trying to increase access to a poorer service. It should also be overtly acknowledged that provision of abortion is not a solution for social deprivation or economic disadvantage.
This policy and the current abortion procedure in Wales fails to educate women on what an abortion is and the reality that the cells inside them have a heart beat from 5 weeks. It is really concerning how we have a consultation on the degrading of human life.
I believe that human life is precious and God given, I don't believe we have a right to take that life away. I also would like to see medical and admin staff protected by articles 9 of the European convention of human rights which protects freedom of conscience so that they won't be forced to post abortion pills etc
My sister had an abortion that she has always regretted. It has had an effect on her mental health. Also, when I was in hospital being sterilised I sat beside a young woman who did not want to have the child aborted but its father had pressured her into it stating that he would leave her if she had the little one. All mothers should have the opportunity for a full discussion on the reasons why she wishes to have an abortion and not just given/posted pills to help her in this. Who knows the mental torment the mother goes through? On the other hand, abortion may be looked upon as just another form of contraception. Would you do this to an animal? Why then to a small and vulnerable human being and its mother?
As I have said a number of times in this consultation document, we are talking about a human life - not just a foetus. Pregnant women should be allowed the opportunity to see that the life that is growing within them is not merely a clump of cells, just as you and I are not just a clump of cells. This legislation will inevitably contribute to keeping abortion numbers high and cheapens the value of human life.
Taking abortion pills at home is promoted as being safe and simple, but it is fraught with risks and complications, as well as being traumatic for women. Many of the risks to women from DIY abortions are the same as with abortions carried out under medical supervision. Medical abortions are being prioritised despite complications after medical abortion being four times higher than after surgical (Niinimaki M et al. (2009) Immediate Complications After Medical Compared With Surgical Termination of Pregnancy. Obstet Gynecol 114:795-804) 20% compared with 5%. Allowing women to perform their own abortions at home should be stopped immediately. The Government should undertake a public information campaign to inform all women of the risks they run in having an abortion.
Abortion clinics are open, The measure, we were informed at the time, was of a temporary nature. The Government should keep to its promise. There is increasing evidence of cases of women enduring pain, trauma and complications. The policy is far from being safe and simple. Most women are unaware of the general risks of having an abortion. More needs to be done to provide such information.
Making abortion pills so easily available will inevitably contribute to keeping the numbers of abortions high, and cheapen the value of human life. This is morally and ethically wrong in today's Welsh society and nation.
Pregnant women should be allowed the opportunity to see that their pregnancy is a human life, and not a clump fo cells, for example, the heart starts pumping blood from five weeks, and from nine weeks fingerprint are evident. As the pill becomes easily available ,the number of abortion will get higher and higher and the value of human life will become cheaper and cheaper.Abortion is not the answer it leaves lasting regret of taking the life of their unborn baby.
When women are offered counseling about terminating a pregnancy is equal prominence given to the case for the unborn child? If not, it should be. After conception another human life is involved in the equation. It's rights also should be represented.
No... thank you, I think you have covered most things . Thanks again.
The construction and definition of 'home' in the current home-use provision is discriminatory against some women as it restricts access. There are a number of reasons why a woman would be safer if the medication is sent to a location other than her home (such as a friend's house or her place of employment), for example: women who will experience shame and stigma if it becomes known that they have attempted to procure an abortion, and women who are living within controlling and abusive environments, such as intimate partner violence and abuse, or familial abuse.
The policy of allowing home abortions was bought in as a temporary emergency measure while abortion clinics were closed as part of lockdown measures. The government should now end this approval since clinics are now open again. The idea of making this permanent is cynical and will put more vulnerable people at risk.

The government should undertake a public information campaign to inform all women of the risks they run in having an abortion.
It is worth pointing out that the abortion provider Marie Stopes believes that this service is not safe and devalues women by not attending to their safety and wellbeing.
What about the well being of women who are getting an abortion?
The issue of the drug manufactures' involvement the in the promotion and delivery of home abortion services needs to be scrutinised. The Welsh Government and Welsh health services must insure that drug company profit is not being allowed to influence any health policy.
There needs to be a face to face follow up appointment after taking the pills to ensure that there are no after effects.
None
I find it odd and offensive that in questions 6,7,9 and 10 you use the term 'people' instead of 'women'. I would like to register a formal complaint about this dehumanising language, which I believe discriminates against women. Thank you.
This measure was brought in as a temporary measure without proper parliamentary scrutiny. DIY home abortion is promoted as being safe, easy and comfortable, whereas for many women the exact opposite is the case. The psychological, emotional and physical risks are great, and there are many reports of the practice being traumatic for women. The government fails in its duty if it does not warn all women of the risks they run in having such abortions.
Having an abortion often leaves a woman with a lifetime regret, especially as they may never have a chance to have another child.
Abortion services & choices effect & apply to women & girls not 'people'. Stop erasing female terms from your documents, you wouldn't do this to men, if you were consulting on prostate cancer services would you? Women are getting tired of this Welsh Govt tendency to make everything that affects women 'gender neutral', please stop; sex-based rights matter & can only be protected if you recognise women as a sex-class. Sex, not gender, is a protected characteristic.
I would have preferred to have seen the terms 'women' and 'girls' used in this questionnaire rather than merely at the beginning. When the language changed to 'people', it became inclusive of transmen yet excludes the majority of those who would be using this service, which are, women and girls. The health care professionals in the NHS are able to professionally evaluate and change language as appropriate to the client being cared for. What this accomodation is doing is prioritising the tiny percentage of transmen rather than centering those who need this service and require it to acknowledge their biological reality not the social construct of gender choice.
The pandemic has brought many changes to healthcare and society in general, but the increased use of technology including telemedicine in healthcare services (not just abortion) has been a change for the better. Now we know what we know about telemedicine and in particular its use in abortion services, the reversal of this legislation simply cannot be justified. To take away an option that is easier, safer, quicker and preferable to women for now clinical or safety reason cannot reaonsed and would be a huge step backwards.
None
DIY abortions were brought in as a temporary measure. Clinics are now open again so women can get proper assessments. Taking abortion pills at home is promoted as being safe and simple but it has proved to be fraught with risks and complications as well as being traumatic for women. There needs to be public information to inform women of the risks they run in having an abortion.
I am more than disappointed at the way the questions are phrased in this consultation. I would have thought Welsh Government would have been more objective and professional in its approach to such an emotive subject.
no comment
I have personal experience of an abusive partner pressuring me into taking what was known as 'the morning after pill' and know, had I not been strong enough to resist being cajoled into taking something harmful to my physical and emotional health, I would have regretted it. I dread to think how a young, or otherwise, vulnerable woman copes on her own, during the painful expulsion then, the distressing disposal of the results. It is, to me, a monstrous experience to contemplate
Allowing women to perform their own abortions at home should end immediately – this policy was never brought in with the intention of making it permanent, the government had promised it was purely a lockdown measure. Clinics are now open again, so women can go in to get the proper assessment. All women need to have an in-clinic assessment as part of their abortion care pathway. Taking abortion pills at home is promoted as being safe and simple, but it is fraught with risks and complications, as well as being traumatic for women. The government should undertake a public information campaign to inform all women of the risks they run in having an abortion.
Pregnancy allows the development of a human life. A woman should be helped to see that even at 10-weeks gestation there is real human forming within the womb. Making abortion even easier with the extension of this home-procedure devalues the humanity of the living child in the womb.
This questionnaire does not consider the massive change that is being proposed to make abortion legal in some circumstances where a mother requests to a default situation where abortion is legal in all circumstances with any consultation for 1st 10 weeks. Given that this will be done privately in homes, our society will not even know how many unborn children have been flushed away. Ethically, this is indefensible. It's simply wrong.

After I gave birth to my first child I had an anti d injection because I had a rhesus negative blood group - this was to eliminate the possibility of my antibodies attacking a future baby that could be rhesus positive . I don't know if this is considered for termination but again if it is,then it puts women at risk if unsupervised. Having an abortion is never an easy decision for a woman and without counselling and support it maybe a regret they have to live with for the rest of their lives
As a healthcare professional involved in abortion care, I would feel ethically and professionally compromised if telemedicine for abortion care was rescinded, compelling me to offer a service that is short of clinical best practice for no clinically justifiable reason.
- Any decision not to continue home-use of misoprostol and mifepristone would be a political decision based on a desire to restrict access to abortion, and would not be based on any scientific or medical evidence - I urge ministers to read the evidence https://doi.org/10.1111/1471-0528.16668 - Mifepristone is one of the safest drugs, safer than viagra, and there is no rationale at all for restricting it - The 10 week limit is arbitrary as evidenced in NICE guidelines - As a healthcare professional, I would feel extremely uncomfortable not providing this service, considering it is the BEST EVIDENCE-BASED service and kinder to patients.
Misoprostol has been used safely for home abortion for a long period. Mifepristone has an excellent safety profile and there is no reason why this should be restricted.
The Catholic Medical Association (UK) [CMA (UK)] has members in both the North Wales and South Wales regions. Since May 2020, the CMA (UK) has provided a service for woman who request ""abortion pill rescue"" therapy. Those seeking this service are pregnant women who have initially taken the first abortion pill, Mifepristone, but who, shortly afterwards, change their minds and wish to preserve their pregnancies and save their babies' lives. There is increasing evidence that early provision of high-dose Progesterone therapy can sometimes (in 50-70% of such situations) preserve the pregnancy by counteracting the effects of Mifepristone. When the service was initially introduced last year, in response to the demand from these women in distress, it was estimated that no more than 10-20 requests might be made for this rescue treatment per year. In less than 10 months since the service was started, however, more than 110 requests for rescue treatment have already been made. This represents a 10-15 fold higher than expected demand for this service. It is worth pointing out that this is also a largely unknown service at present. It is very likely that the temporary measure of allowing early medical abortions to be carried out without proper consultations has resulted in many young women making decisions to abort in a panic that they very quickly regret. We know this because many of the young women who seek our help have informed us that they felt under pressure to proceed with abortion during and after the telephone consultations they experienced with the abortion providers. Many felt that they were not given the time to adequately make an informed decision with sufficient counselling before taking the Mifepristone tablet. This problem will be aggravated by making the temporary measure permanent.
None of your questions concern the unborn baby, whose life hangs in the balance. Scientific consensus has established that life begins at conception, we therefore have another life to consider here apart from the mother's and her family, and the NHS staff. I think it is most important that this consultation considers what exactly is the service you are providing. A medical abortion is the killing of another human being and the ejection of that human from what should be the safest place. Hundreds of lives will be lost every day as a result of this arrangement.
There can be huge emotional consequences in the termination of pregnancy which may not emerge for many years. By making abortion a mail order procedure - which is effectively what the temporary measures achieved - it is trivialising the value of human life and falsely imply that abortion is without consequence, but that is not the lived experience of many women.
The EMA at home model demonstrates how a permissive framework for medical abortion can deliver significant quality improvements to those needing to access abortion care. There was no decrease in effectiveness when compared to a traditional in-person model, but the no-test telemedicine pathway improved access to care, was highly acceptable to patients and is likely to be especially beneficial for vulnerable groups and in resource-poor settings.
Clinics are now open again, so women can go in to get the proper assessment. All women need to have an in-clinic assessment as part of their abortion care pathway.
Allowing women to perform their own abortions at home should end immediately – this policy was never brought in with the intention of making it permanent, the government had promised it was purely a lockdown measure. Clinics are now open again or will soon, so women can go in to get the proper assessment. All women need to have an in-clinic assessment as part of their abortion care pathway. Taking abortion pills at home is promoted as being safe and simple, but it is fraught with risks and complications, as well as being traumatic for women. The government should undertake a public information campaign to inform all women of the risks they run in having an abortion.
Just to reiterate again that these changes should absolutely be made permanent. There are no logical, moral, or medical reasons for them not to be. To return to the previous state of affairs would send a clear message that the Welsh Government would rather pander to a small group of evangelical extremists than to protect the health of a significant proportion of Welsh citizens. Frankly, there should not be a consultation at all - it is a straightforward clinical decision. It is not a debate about whether abortion should be provided at all, but one about how we can ensure such care is provided in the safest way possible.
Doctors for Choice UK members are unanimous in their support of telemedicine in abortion care. This is because it allows staff to provide a better quality of care to women who need an abortion, rather than requiring everyone to attend a clinic for prolonged periods while the requirements of the Abortion Act are met. The regulations allow for greater workforce flexibility, allowing doctors who are shielding or self-isolating, or with childcare commitments to work from home, leading to a more efficient and cost-effective service.
The Welsh approval for mifepristone at home differs from the Scottish approval in two key ways: • The gestational limit is included in law; and

• There is a link to provision from a hospital or licensed premises. Both of these can place additional pressures on providers and women in receiving the best possible care. The ability to provide the best possible abortion care in Wales should be governed by clinical frameworks and guidelines, and not by the criminal law. In Scotland, the Scottish Abortion Care Providers network determined that 12 weeks' gestation was the more appropriate limit for home use of mifepristone and misoprostol – a finding supported by international evidence. Their framing also better allows effective cross-border care, and care grounded in the qualifications of clinicians providing care (doctors, nurses, and midwives in the case of Wales) rather than it being tied to other licensed premises. The ability to provide mifepristone at home would also help women in Wales having later abortions, including on the grounds of severe or fatal fetal abnormality, who would no longer need to attend multiple, unnecessary appointments. Instead, they could take mifepristone at home before attending to pass the pregnancy in hospital. We would recommend that the Welsh approval of mifepristone at home is made permanent, but that it is reframed to reflect the Scottish approval – without a gestational limit in law, and focused on the qualifications of the doctors, nurses, and midwives providing abortion care.
Allowing women to perform their own abortions at home should end immediately – this policy was never brought in with the intention of making it permanent, the government had promised it was purely a lockdown measure.
as an experienced GP and family planning doctor with decades of experience I hope my comments will be given due consideration. There are still many barriers to free and equal access to (legal) NHS abortion services and I can see online service provision and pills at home will be a good step forward
There are some issues with the temporary approval order that can be addressed in making a permanent approval order. First, the definition of home where the medications can be lawfully taken is defined as the place in Wales where the person receiving treatment is ordinarily resident. However, this is unduly restricted. That the home is defined in this way does prevent some potentially vulnerable groups from accessing care outside of a clinic including minors in foster care, or students in temporary accommodation (Lohr and others 2020). It also prevents individuals from, technically, lawfully administered the abortion medications in a place that is not their home where they might feel safe – including a friend or family member's home. Second, the gestational limit placed on home use of both medications in Wales is defined in the temporary approval order. It was not in the Scottish order and was instead left to professional guidance to determine. This is more appropriate because it allows medical professionals and service providers to safely adapt care provision in line with the evidence. The Scottish Abortion Care Providers recommend that home use can be undertaken until 11 weeks and days' gestation (Scottish Government 2020; Parsons and Romanis 2021). There is evidence that this is safe. The two weeks difference might seem small – but it might make a significant difference for a small number of people who need access to abortion within this time frame (between 10 and 12 weeks). It would be discriminatory to prevent people in Wales from having this care at home when it would be more comfortable for them, when people in Scotland are able to do so perfectly safely. Furthermore, it is important that clinical discretion on this matter is preserved, as is better achieved by the approach in the Scottish temporary order. I would recommend that a permanent order either remove a gestational limit and stipulate that medical guidance will determine the appropriate limit – or, the limit be extended to 11 weeks 6 days in line with the evidence. References: Lohr, P and others. 2020. 'How would decriminalisation affect women's health?' in S Sheldon and K Wellings (eds), Decriminalising Abortion in the UK: What Would it Mean? Bristol: Bristol Policy Press. Parsons, JA and Romanis EC. 2021. '2020 developments in the provision of early medical abortion by telemedicine in the UK.' Health Policy 125 (1): 17-21. Scottish Government 2020. The Abortion Act 1967 (Place for Treatment for the Termination of Pregnancy) (Approval) (Scotland) 2020.
The heartbreaking impact of terminations because patients have not been offered a mental health professional to explore their decision, I have met many women who deeply regret termination and state they never made an informed decision at the time and they regret their decision to terminate.
Clinics are now open so women can get in to get proper and safe treatment. The ""pills by post"" arrangements were meant to be a temporary measure. Taking these drugs at home is fraught with danger.
I support the rights of the unborn. A gestation of up to 10 weeks is not a clump of cells, but a life and with prospects of a profitable future if left alone.
I believe that this measure will open the door for some people to treat abortion as a form of birth control. As a result abortion rates will remain high and may even increase. Every pregnant woman should be allowed the opportunity to see that their pregnancy is a human life, and should be told the basic facts about their unborn baby, eg. the heart starts pumping blood from five weeks, and from week 9 fingerprints are evident. Many women speak later on of regrets at having had an abortion. All these things must be taken in to consideration.
There is no. Obligation on the NHS to provide post-termination support to patients and deal with post termination grief or other support. Why not use the 3rd sector as this is part of the commitment of the BCUHT . This appointment should be give at the time of the termination and not be with the provider who has a vested interest.[eg BPAS / Marie Stopes]. There has been no scrutiny or public debate in this, one lobbying by financially interested parties and thats not good practice for safeguarding the woman or her unborn child.
Women should not be allowed to carry out such a serious medical procedure at home without medical supervision. This needs to be stopped at once. This was supposed to be a measure for lockdown only. I remember a government

minister saying it was unsafe only a week before it was agreed to bring it in. Clinics are now open again so there is no justification for putting women's lives at increased risk. Every woman's life matters and every woman seeking an abortion should have the best care and, patently, home abortions without face to face consultations with medical professional in a safe place falls well below best practice.
none
The foetus is a human life not a clump of cells. Even in difficult rape cases there is no justification for taking an innocent human life.
Allowing women to perform their own abortions at home should end immediately – this policy was never brought in with the intention of making it permanent, the government had promised it was purely a lockdown measure. Clinics are now open again, so women can go in to get the proper assessment. All women need to have an in-clinic assessment as part of their abortion care pathway. Taking abortion pills at home is promoted as being safe and simple, but it is fraught with risks and complications, as well as being traumatic for women. The government should undertake a public information campaign to inform all women of the risks they run in having an abortion.
It was never intended that this should be anything other than a temporary arrangement, instigated because of closure of clinics because of the Covid-19 pandemic. Clinics are already operating again, allowing women to be properly and safely assessed. The ""pills at home"" arrangement should be terminated as soon as possible; until it is, women should be clearly informed of the possible complications and the risks to their physical and mental health (not to mention that of their unborn babies). ""Pills at home"" is not anywhere as safe and straightforward as it is made out to be.
Taking the life of an unborn baby is never the answer. The use of Home abortion has increased the dangers to those undertaking the procedure. It seems a bit like going back to 'back-street abortions' of bygone ages, which were unsafe and resulted in severe medical complications and death.
This measure was initially brought in to be temporary, during the first lockdown. Given that clinics are now open again, there is no need for this measure to continue.
The approach of the consultation fails to recognise that abortion in any setting takes a human life. As set out in previous answers, abortion can also have significant consequences for the health of the mother. Pregnant women should be allowed the opportunity to see that their pregnancy is a human life. It is right that pregnant women know that the life inside them is not merely a clump of cells, in the same way that adult human beings are not merely clumps of cells. Women should be told basic facts about their unborn babies. For example, the heart starts pumping blood from five weeks, and from week nine fingerprints are evident. Making abortion pills so easily available will inevitably contribute to keeping the numbers of abortions high, and cheapen the value of human life. Having an abortion is never the answer. Even in situations like rape, women have spoken of the lasting regret they felt at taking the life of their unborn baby.
Most reasonable people would accept that abortion is not something they want to see in increased numbers, as opposed to the safe delivery of children who are in practice normally raised and loved by the woman who gives birth, even if the pregnancy was initially unwanted. Abortion in our view represents a serious social failure and injustice both as regards the woman and as regards her unborn child. That said, we would support purely restrictive measures to ensure that no part of the abortion process is performed in a home setting, together with serious positive efforts to connect women in crisis with government and voluntary help to have their babies.
Allowing women to perform their own abortions at home should end immediately – this policy was not brought in as a permanent measure, the government had promised it was purely a lockdown measure. Taking abortion pills at home is promoted as being safe and simple, but there are many risks and potential complications, as well as it being potentially highly traumatic for women.
Lay people including family members need support at this time and health providers need to be mindful of their responsibility for such momentous actions. Litigation can be envisaged in the event of PTSD.
We would like to reiterate our concerns regarding the following issues around safety: One cannot guarantee without seeing the woman what gestational age she is at. She could be taking the pills for a pregnancy that is greater than 9 weeks and 6 days. BPAS was reported earlier this year to be investigating 9 cases where women have taken the pills after the 10 week limit with one of those identified as being 28 weeks . If this happens it could have grave health implications for women. In addition, at 28 weeks, the baby would have had over 90 percent chance of survival. There is a risk of haemorrhage in medically induced abortion. The NHS in describing the risk of bleeding in medical abortions says “serious complications such as heavy bleeding, damage to the womb, or sepsis: this happens to about 1 out of 1,000 women” (https://www.nhs.uk/conditions/abortion/risks/). We would point out that if women are bleeding excessively and do not receive urgent medical intervention, this can put their lives at risk. The NHS says 7 out of every 100 medical abortions up to 14 weeks require further procedures to remove “parts of the pregnancy” that have stayed in the womb. The abortion provider BPAS says between 3-7 out of every 100 women who are between 9-10 weeks, may experience continuing pregnancy, retained pregnancy tissue or need surgery to complete the abortion . For the first three months of the lockdown this year 3% of the medical abortions which took place at home would account for 690 women who were at risk of needing follow up surgical procedures after a medical abortion. We can envisage situations where teenagers are having the abortions secretly and having to deal with the shock of seeing the result of the abortion. These can have long term traumatic consequences for her which she has to deal with all on her own.

Where safeguarding is concerned, we are worried about women and young girls in abusive relationships being coerced into taking these pills by abusers and groomers to hide their crimes. When abortions are procured without the physical input of doctors we cannot ascertain for sure if the pills are to be used by the caller or if she's obtaining them for someone else. We would also have no idea if she is being threatened into getting them by an abuser.
The Evangelical Alliance is a unity movement representing thousands of individuals, churches and organisations. We believe in the value of human life and this legislation degrades it. Both the life of the child and the safety of the woman are compromised. We propose that this legislation should be ended immediately and that women's homes in England should no longer be a place where the second set of pills can be administered. Clinics are now open again, so women can go in to get the proper assessment. The fact that this policy was never brought in with the intention of making it permanent, the government had promised it was purely a lockdown measure, means that there is no reason to continue this legislation under the guise of protection from COVID-19. Abortions are a life-altering and sensitive issue, with high rates of women experiencing some form of mental health issue, so for women to go through the process without any human, in-person interaction shows a lack of concern for the mental wellbeing of the women. On top of this, the woman is told to look away during the abortion process as they can see a baby being disposed of, which is a chilling image that stays with people long term. Lastly, the Government should undertake a public information campaign to inform all women of the risks they run in having an abortion. Many of the EMA related studies are ran with a pro-choice agenda, aiming to result in an outcome that stresses the simplicity of medical, at home abortions. So for the sake of women's safety, more information should be made known to women considering EMA at home.
None to see
Making abortion pills so easily accessible will inevitably contribute to the alarming increase in the termination of life. It would seem to cheapen the value of each precious human life, at whatever stage this is carried out. In a society where we seem to purchase every commodity ""ONLINE"" it would appear that "" human life"" has been demoted to this level. Women should be given the opportunity to see that their pregnancy as a human life, not just a bundle of cells
I think that the recent addition of non-gendered language is an unnecessary confusion to the issue. As a biological sciences graduate, I think that we can dispense with deluding ourselves with politicised jargon. The textbook definition of an embryo is ""The fusion of two gametes to form a zygote"". Can we not agree that the gametes required are an ovum and a spermatozoa? And these such gametes come from a female and male respectively. Although this fusion can take place in vitro, the nurturing environment of a female womb is the optimum place for the embryo to become a foetus, which differentiates to a boy or girl by the 13th week. This information should be made available and UNDERSTANDABLE, in whatever language (have you considered training interpreters for the hearing impaired?) to both prospective parents, so that they are aware of the gravity of such a decision to proceed with a termination of their baby's life.
The English and Welsh governments are planning routes out of lockdown. Reopening clinics to scan every patient requesting an abortion, both to date the pregnancy accurately and to confirm an intrauterine pregnancy, and to ensure every patient has a private face to face conversation with a clinician, along with the repeal of the temporary approval for remote consultation and taking both sets of pills at home, are key steps that should happen as part of that planning.
Allowing women to perform their own abortions at home should end immediately – this policy was never brought in with the intention of making it permanent, the government had promised it was purely a lockdown measure. Clinics are now open again, so women can go in to get the proper assessment. All women need to have an in-clinic assessment as part of their abortion care pathway. Taking abortion pills at home is promoted as being safe and simple, but it is fraught with risks and complications, as well as being traumatic for women. Complications after medical abortion are four times higher than after surgical abortion. The government should undertake a public information campaign to inform all women of the risks they run in having an abortion.
- Allowing women to perform their own abortions at home should end immediately. This policy was never brought in with the intention of making it permanent, the government had promised it was purely a lockdown measure. - Clinics are now open again, so women can go in to get the proper assessment. - All women need to have an in-clinic assessment as part of their abortion care pathway. - Taking abortion pills at home is promoted as being safe and simple, but it is fraught with risks and complications, as well as being traumatic for women. - The government should undertake a public information campaign to inform all women of the risks they run in having an abortion.
If an ultrasound scan was deemed necessary to date the pregnancy, detect twin or more pregnancies, and check for ectopic pregnancies, it is reasonable to assume that there are risks to missing out this step - for example, a risk that the woman is further on than assumed or of an ectopic being missed. If a woman is pregnant with e.g. twins that can be vital information in her decision making - can she give proper consent to terminating a pregnancy when she doesn't know if she is has a multiple pregnancy or not?

Also, I have heard many women talk about the importance of the gestational age for them - for example, they may say they wanted to make sure the termination was before 8 weeks or before 10 weeks as they felt they ""couldn't have"" gone through with it after a certain point. If the pregnancy is not being reliably dated, how does that impact Informed Consent? No scan also means no possibility of a scan picture - women often talk about wanting to ask for their scan picture and, if they have one, it can be very significant and precious for them, it can be the only thing they have from the pregnancy, no matter how early or undefined the image may be. When a woman has been pressurised or coerced into an abortion, or for whatever reason regrets it afterwards, that image can be of huge importance. Women have also discussed how they wished they had looked at the scan as they might have changed their minds. Cutting out the scan not only reduces an opportunity for more fully informed choice to go ahead or not, but it also risks adding to women's grief and regrets afterwards. How scans are conducted prior to termination would benefit from a review in light of women's experiences at the time and in the years after abortion. Removing the scan disregards both physical and mental risks, as well as undermining Informed Consent.
1) The Welsh Government needs to recognise that abortion is an act of violence and, as has been seen throughout human history, violence begets violence and begin to tackle its relatively high rates of abortion compared to other European countries. The Consultation contradicts the UK Government's own strategy to tackle domestic abuse by asking for opinions on removing a clinic appointment where abuse can be identified, and lacks the holistic acknowledgement of the problems abortion causes. The similar Consultation in Scotland acknowledged possible links to domestic abuse, mental health concerns, and human trafficking which is absent in the Welsh Consultation indicating it is flawed. 2) The disproportionate loss of black and ethnic minority unborn children and so lack of care for black and ethnic minority women could be considered institutional racism by definition of the Lawrence Report (1999) as "the collective failure of an organization to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin seen or detected in processes, attitudes and behaviour that amount to discrimination through …ignorance and thoughtlessness…. which disadvantage minority ethnic people." (https://en.wikipedia.org/wiki/Institutional_racism) 3) Some areas of Wales are extremely remote and there is no acknowledgement in the Consultation that the problems associated with medical abortion pills for women would be exacerbated in these circumstances. 4) Contraceptive failure accounts for just over half of abortions in England & Wales according to the British Pregnancy Advisory Service (https://www.bbc.co.uk/news/health-40520235, sic headline) meaning reproductive health services in England & Wales are not fit for purpose and are a large part of the problem of the record numbers of abortions in 2019. For example, natural family planning (such as within marriage) is a credible way of averting the loss of unborn children and is 2.5 times more effective in perfect use at preventing pregnancy than the progestogen-only oral contraceptive pill which is given to many hundreds of thousands of women in Great Britain. 5) A vote on 'DIY home abortions' was pulled by Diana Johnson MP in the UK Parliament in September 2020 because there was no majority support among MPs or the country for an unpleasant procedure to be undertaken in this way with such a lack of care and respect for women, families, and unborn children. Evidence indicates this lack of care and respect is being reflected in the way men treat women which needs to change.
The government brought in this policy because of the lockdown. They promised it would not be permanent.

Consultation Response Form

Your name: ***[information redacted]***

Organisation (if applicable): Faculty of Sexual and Reproductive Healthcare (FSRH)

email / telephone number:

[informationredacted]

Your address: ***[information redacted]***

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.** 1. The Faculty of Sexual and Reproductive Healthcare (FSRH) welcomes the opportunity to respond to the Welsh Government's consultation on termination of pregnancy arrangements in Wales. FSRH is the largest UK multidisciplinary professional membership organisation representing more than 15,000 doctors and nurses working at the frontline of Sexual and Reproductive Healthcare (SRH) care delivery, including abortion care in Wales. Our goal is to ensure that the population can access high-quality and holistic SRH services across the life course, and that essential SRH services remain available to the population during and after the COVID-19 pandemic. 2. FSRH supports the proposal to make permanent the current temporary approval allowing for home use of both pills, mifepristone and misoprostol, for Early Medical Abortion (EMA) for all eligible women in Wales, up to 9 weeks and 6 days gestation. Our members report that this measure has had an overwhelmingly positive impact on the provision of abortion services for women accessing these services. 3. The temporary measure has had a positive impact by making abortion care more accessible and convenient. Evidence demonstrates that the remote care pathway facilitated by the temporary approval order has been safe, accessible and acceptable for women, with no added risk of negative outcomes associated with home use of both pills. It has enabled women and girls to access abortion care from the safety and comfort of their own home, without unnecessary exposure to the risk of infection from COVID-19. 4. In this consultation response, we present the findings from the recently launched national cohort study by Aiken et al of data from the following independent abortion care providers: British Pregnancy Advisory Service (BPAS), MSI Reproductive Choices and the National Unplanned Pregnancy

Advice Service (NUPAS).[1] The study sample represents 85% of the total number of medical abortions performed in England and Wales during the study period. The study sample includes all patients who accessed EMA from these three providers during the two months before and two months after the service model changed. A comparison was made between 22,158 women accessing EMA between 1 January and 1 March 2020 (the traditional cohort involving face-to-face consultations) and 29,984 accessing EMA between 6 April and 30 June 2020 (the telemedicine cohort involving a telephone consultation and home use of both abortion pills). In the latter cohort, 61% of patients were treated entirely by telemedicine. This study is not only scientifically robust but also reports on the real-world experience of how the entire service was delivered.

5. Abortions carry a reduced risk of complications the earlier in the pregnancy they are performed. Aiken et al found that average waiting times were 4.2 days shorter in the telemedicine cohort, and that 40% of abortions were provided at under 6 weeks' gestation compared to 25% in the traditional cohort.

6. Aiken et al found that identification of potential complications, including ectopic pregnancies, is as effective in telemedicine EMA pathways as in traditional pathways. The incidence of ectopic pregnancy was equivalent in both cohorts, with no significant difference in the proportions being treated after abortion.

7. A post-abortion survey of telemedicine patients by MSI Reproductive Choices found that 87% of women receiving care had no concerns about the safety of taking both abortion pills by themselves. [2] Those with concerns reported a general anxiety around the procedure, including whether it would work, what level of bleeding and pain to expect, and how they would cope if they experienced complications. These concerns do not relate specifically to the at-home administration of mifepristone and would apply equally to the EMA pathway available to women before the introduction of telemedicine for abortion. Moreover, these concerns were often alleviated through further telephone support.

8. In a systematic review of telemedicine for abortion care, the National Institute for Health and Care Excellence (NICE) noted that telemedicine is likely to improve access, especially for vulnerable groups.[3] Many women face barriers in attending face-to-face services, e.g. due to lack of transport arrangements, disability, child-care responsibilities, or abusive relationships. Remote access to abortion services is vital in ensuring that these women can access care.

	9. This measure also protects patients and clinic staff from unnecessary exposure to COVID-19 infection. A British Pregnancy Advisory Service (BPAS) survey, included in Aiken et al's study, found that 2.8% of women choosing to receive both abortion pills by post explicitly mentioned self-isolating or shielding at the time of their EMA. The approval order has enabled these women to access critical healthcare while reducing exposureto the COVID-19, as well as minimising related anxiety. 10. Data show overwhelmingly that the home use of abortion pills is preferred by women. A survey by MSI Reproductive Choices to assess patient experience[4] found that: • **83.3% would not have preferred a face-to-face pathway.** • 92.4% reported they had enough information to manage the process at home • 87.4% had no concerns about taking the medication by themselves • 98.2% rated their experience as good/very good • 95.3% patients felt able to talk privately • 99.3% had the opportunity to ask any questions 11. A similar survey by the British Pregnancy Advisory Service, included in Aiken et al's study, found that: • 96% were satisfied or very satisfied with the service • 80% would choose to receive remote care even if the option of face-to-face care were available. [1]Aiken, Lohr, Lord, Ghosh, & Starling, 2020. *Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study.* [2] Erlank, Lord, & Church, 2020. *Early medical abortion using telemedicine – acceptability to patients.* [3] NICE, 2019. *Abortion care guideline evidence review.* [4] NICE, 2019. *Abortion care.*

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.** 1. The temporary measure has been positively regarded by abortion care providers and has had a positive impact on the healthcare service. Remote consultations save time, which enables healthcare providers to see more patients and reduce waiting times. Telemedicine also allows healthcare providers to work more flexibly, for example if they need to work from home when shielding. Healthcare providers can continue to provide care safely, without the risk of contracting COVID-19 in a clinic setting.

	2. An FSRH member and abortion care lead in Wales said "From the perspective of my Health Board and Wales generally these temporary changes have revolutionised abortion care in Wales. I lead the abortion services in Swansea Bay Health Board. We have been trying nationally for years to get our waiting times down to the RCOG recommended limit of five days. Since these temporary legal changes this has finally been achieved. The waiting times have reduced from a couple of weeks to a couple of days. The average gestation at abortion has also reduced, from 8 weeks to 6 weeks. We manage more patients outside the hospital, and we manage less patients surgically than before. The complication rate has not increased. The patients are very happy with this new way of working. It involved less travel and less time off work for our patients. The risk of COVID transmission, as well as other infections, has obviously been reduced. This will need to continue. I very much hope that these legal changes can be made permanent." 3. A further FSRH member and abortion service lead in Wales said: "The implementation of the temporary approval has had an enormous impact both on the local health economy and on the improvement of care for women. Women have a shorter wait to their appointment, are seen at an earlier gestation, experience far shorter waits in clinic, have improved patient experience and there have been fewer failed procedures or complications." 4. The continued provision of telemedicine abortion services would result in substantial savings to the NHS. The National Institute for Health and Care Excellence (NICE) found that for every day's reduction in waiting time, the NHS in England would save £1.6m per year owing to reduced complications and fewer needing to opt for a surgical abortion.[4]

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. We do not consider that there are any additional risks associated with the temporary measure. Of the potential risks that have been raised, none are supported by evidence. These potential risks are a) uncertain gestational age due to lack of routine ultrasound scanning, b) late diagnosis of an ectopic pregnancy, c) difficulty in perception of non-verbal cues relevant to an unstable decision about abortion and to safeguarding issues and d) committing to initiation of the abortion process and taking the medicines away from medical supervision. 2. Regarding a), Aiken et al's national cohort study of telemedicine for abortion found just 11 cases out of 29,984 (0.04%) in the telemedicine cohort in which the gestational age after abortion was reported as being greater than the expected 10 weeks. In all these cases, the medical abortion was completed

at home without additional complications. In a further study of 663 women in Scotland who took both abortion pills at home and did not receive an ultrasound, no patients were inadvertently treated beyond the gestational limit for medical abortion. The authors concluded that "telemedicine abortion without routine ultrasound is safe, and has high efficacy and high acceptability among women".[5]

3. Regarding b), routine ultrasound scanning is not clinically necessary unless women have risk factors for or symptoms suggestive of an ectopic pregnancy. Aiken et al's study found no statistically significant difference between the telemedicine cohort and the traditional pathway cohort in the prevalence of serious adverse events, and the incidence of ectopic pregnancy was equivalent in both cohorts. This suggests that screening processes for potential contraindications are as effective in the telemedicine pathway as the traditional pathway. Women with complex care needs which necessitate face-to-face consultations and scans will continue to access them. Aiken et al outline that routine scanning in symptom-free, pregnant women without risk factors may aid detection of some cases but falsely reassure others that a pregnancy is intrauterine. The absolute incidence of ectopic pregnancy in those undergoing abortion is ten times lower than that in women who wish to continue with their pregnancy. Pregnant women who wish to continue their pregnancy are not seen in person and scanned unless they have symptoms of an ectopic pregnancy. There is therefore no clinical justification for maintaining an inconsistency in care between those continuing their pregnancy and those choosing EMA.

4. Regarding c), the experience of FSRH members is that women can talk more freely and openly when consulting over the phone than in a clinic. Many people are intimidated by medical consultations and, with abortion care being so intensely personal and private, face-to-face discussions can be perceived as threatening. Many women expect to be judged given the stigma attached to abortion care, an expectation reinforced by the frequent protests that occur outside abortion clinics. In contrast, people are used to talking over the phone and when consultations are conducted from the privacy and safety of their own home, they are more likely to be open and honest, rather than feeling obliged to offer answers they perceive to be expected of them. This impression is borne out by consultations often taking longer over the phone – as the patients simply talk more – and that rates of identification of safeguarding issues have increased.

5. Regarding d), evidence collected during the COVID-19 pandemic clearly demonstrates that women have the capacity to make the decision to take mifepristone, the first abortion pill, by themselves in the privacy of their homes. Taking both mifepristone and misoprostol at home has been routine practice across the world for many years and has an excellent safety record. This approach is also preferred by women. A study by MSI Reproductive

	Choices UK found that 92.4% of women reported they had enough information to manage the process at home, and 87.4% had no concerns about taking the medication by themselves (concerns highlighted were general concerns about the effectiveness of the regimen). 6. Finally, abortion providers already include information around potential risks in discussion with clients, and scans are always offered if the client is not confident of the date of their last missed period. Doctors and nurses should be supported to act in good conscience and in the best interests of the patient. It is the FSRH's position that doctors and nurses are the best judges of what they need to discuss with their patients, and that it is unnecessary to impose any additional legal guidance on this matter. [5] Wright, Johnstone, McCabe, Evans, & Cameron, 2021. *Telemedicine medical abortion at home under 12 weeks' gestation: a prospective observational cohort study during the COVID-19 pandemic.*

Q4.	**In your experience, have other NHS Wales services been affected by the temporary approval? If so, which?** 1. Our members based in Wales report that the temporary approval of telemedicine abortion services has reduced the pressure on early pregnancy and gynaecology services, as women are treated at earlier gestation and are thus less likely to experience complications. Without the need for clinically unnecessary ultrasound scans, waiting times and consultation times have been reduced.

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.** 1. There are no benefits in relation to safeguarding or to women's safety in requiring them to make at least one visit to a service. Any requirement for travel to a clinic imposes barriers to care for women, especially for women in marginalised groups. These requirements remove the convenience for all women to choose when to begin their abortion, which has severe implications for specific groups, e.g. women who work in inflexible jobs without paid sick leave, or women solely responsible for the care of young children. 2. Safeguarding processes have been enhanced rather than damaged by the introduction of the telemedicine pathway facilitated by the temporary approval order. In 2020, FSRH conducted a members' survey that received over 1100 responses. Our members reported that women who may previously have felt unable to discuss intimate or distressing details in person can talk more openly via telephone. MSI Reproductive Choices has reported

	an increase in safeguarding disclosures during the pandemic, suggesting that women feel more comfortable disclosing safeguarding issues during remote consultations.[6] While some safeguarding concerns may still warrant a face-to-face consultation, it is likely that any requirement to attend clinic as part of the care pathway would reverse progress in this area, creating barriers to safeguarding disclosures for some vulnerable women. 3. A requirement to attend a clinic to receive abortion care increases waiting times and the average length of gestation at the time of abortion, both of which have fallen substantially since the temporary approval allowing for home use of both pills was introduced. Aiken et al found that average waiting times were 4.2 days shorter in the telemedicine cohort, and 40% were provided at under 6 weeks' gestation compared to 25% in the traditional cohort. 4. While abortion is a clinically extremely safe procedure, and in all cases safer than childbirth, the risk of complications is more marginal the earlier the procedure is carried out. Any requirement resulting in increased waiting times marginally increases the risk of complications by delaying access to abortion care. A requirement to attend a clinic is therefore not in the best interests of all women, though women should retain the option to access face-to-face care after the pandemic if that is their preference. 6 MSI Reproductive Choices, 2020. *Written evidence submitted by Marie Stopes UK (MRS0321).*

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?** 1. In a systematic review of telemedicine for abortion care, NICE noted that telemedicine is likely to improve access, especially for vulnerable groups.[7] We outline a number of groups who particularly benefit from access to telemedicine services. 2. **Young women**. Young people are disproportionately likely to lack the ability to travel for care, and (if they live with parents) may be less able to leave their household to attend a clinic without raising questions. The approval order facilitating a telemedicine pathway for abortion has increased the accessibility of abortion services and enabled women to better maintain privacy. 3. **Black, Asian, and Minority Ethnic (BAME) women and women from religious communities**. Members of all communities across the UK access

	abortion services. However, people from BAME communities and/or religious communities may encounter specific social obstacles, including stigma, if abortion is a controversial issue in their religion or culture. The option to access care at home and without travelling to a clinic will improve ease of access for such women, allowing them to maintain privacy and discretion. 4. **Women with disabilities.** Women with disabilities often face barriers attending services in person, particularly in cases where they do not have their own means of transport or require an escort to attend a clinic. By delivering abortion medication by post, telemedicine makes abortion more accessible for many disabled women. Without telemedicine, there is a real risk that these women are forced to turn to illegal online options because they cannot access care within the formal healthcare system. 5. **Women in abusive relationships or who may be subject to reproductive coercion.** Those in abusive relationships may be unable to travel to a clinic due to the need to conceal their pregnancy from an abuser. The option to access care at home and without travelling to a clinic will improve ease of access for these individuals, allowing them to maintain privacy and discretion. 6. Anti-choice groups often target those accessing an abortion clinic in person. While it can be distressing for anyone to receive this type of harassment, it can be disproportionately distressing for people who are already marginalised by a protected characteristic, such as people of colour, religious people, teenagers, trans or non-binary people, disabled people and people with mental health problems. Many people accessing abortion have experienced rape, abuse or assault. Anti-choice harassment outside clinics can be particularly distressing for these individuals. Telemedicine allows people to avoid this harassment. [7] NICE, 2019. *Abortion care guideline evidence review.*

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?** 1. There are significant socioeconomic and geographical disparities in abortion rates across England and Wales, with women from the lowest decile on the Index of Multiple Deprivation (IMD) twice as likely as women from the highest decile to require an abortion.[8] Women from more deprived backgrounds are also more likely to lack access to a reliable form of transport, to be working inflexible hours or for a job that does not offer sick pay, and to lack access to childcare services.

	2. There are therefore significant and demonstrable benefits associated with allowing women from deprived socioeconomic backgrounds to access abortion care remotely. The removal of the requirement to take mifepristone at an in-clinic appointment removes the need for travel and allows women to begin their abortion at a convenient time, for example to fit with a shift pattern which they may be unable to change. This improves accessibility and ameliorates the likelihood of financial penalties which might otherwise be associated with accessing abortion. 3. In Wales, over 35% of the population live in rural areas. Providing access to health care services is a particular challenge for many areas with dispersed populations. A study by Heller et al[9] found that women living in rural areas face particular barriers accessing abortion care, including the impact of long travel times as well as potential stigma from local healthcare providers. Remote provision of abortion care can enable women in rural areas to access abortion care safely and accessibly. [8] Department of Health and Social Care, 2019. *Abortion statistics, England and Wales* [9] Heller, Purcell, Mackay, Caird, & Cameron, 2016. Barriers to accessing termination of pregnancy in a remote and rural setting: a qualitative study.

Q8.	**Should the temporary measure enabling home use of both pills for EMA:** **1. Become a permanent measure?** **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).** **3. Other [please provide details]?** 1. The temporary home use of both abortion pills for EMA should become a permanent measure.

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:

Consultation Response Form

Your name: ***[information redacted]***

Organisation (if applicable): Hywel Dda UHB

email / telephone number: ***[information redacted]***

Your address: ***[information redacted]***

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.** Yes: the area covered by the Health Board is large in area and very rural in places, which means that travel distances and times are fairly lengthy. The e consultations cover medical considerations, as well as safeguarding issues. If there are any queries about gestation e.g. unsure of LMP or became pregnant whilst taking contraceptive pills, we have the ability to bring the women in to perform an ultrasound scan. The accessibility to the service, with these changes due to Covid 19, has improved dramatically, which then means the EMAH are carried out at lower gestations and waiting times have been much reduced.

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.** Yes: as above. Due to the large geographical area the Health Board covers and the rurality of the region, the fact that the workforce work remotely means much more flexibility in the system. The service is also more efficient in terms of accessibility and waiting times. As there are far fewer face to face appointments required, the service is more efficient and better value for money.

Q3.	**What risks do you consider are associated with the temporary measure? If you consider that there are risks, can these risks be mitigated?** There are minimal risks involved because the consultation allow the correct questioning, and if there are any concerns based on the answers provided the patient will be brought in for an ultrasound scan. The risk of missing an ectopic is not increased, and all the correct information about signs and symptoms are given, and information about where to access care is provided.

Q4.	**In your experience, have other NHS Wales services been affected by the temporary approval? If so, which?** To my knowledge, all Health Boards that provide abortion care have been affected.

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.** During the Covid 19 pandemic, there has been an acceleration in the use of remote technology. There is now the ability to provide consultations through Attend Anywhere, a video consultation package. By using video technology, this will help mitigate safeguarding and safety risks.

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?** The move has improved accessibility for the vast majority of patients that use the abortion service. There is still the provision of face to face consultations if required or felt necessary.

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?** As an extremely rural Health Board, with pockets of economic disadvantage – the availability of EMAH that can be posted out via registered post, has dramatically reduced the differential in accessibility for those who are disadvantaged.

Q8.	**Should the temporary measure enabling home use of both pills for EMA:** 1. **Become a permanent measure?** Absolutely Yes 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).** 3. **Other [please provide details]?**

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:

Consultation Response Form

Your name: ***[information redacted]***

Organisation (if applicable): Hywel Dda UHB

email / telephone number: ***[information redacted]***

Your address: ***[information redacted]***

Consultation questions

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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.** Yes: as above. Due to the large geographical area the Trust covers and the rurality of the region, the fact that the workforce work remotely means much more flexibility in the system. The service is also more efficient in terms of accessibility and waiting times. As there are far fewer face to face appointments required, the service is more efficient and better value for money.

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Q4.	**In your experience, have other NHS Wales services been affected by the temporary approval? If so, which?** To my knowledge, all Health Boards that provide abortion care have been affected.

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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?** As an extremely rural Health Board, with pockets of economic disadvantage – the availability of EMAH that can be posted out via registered post, has dramatically reduced the differential in accessibility for those who are disadvantaged.

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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:

Welsh Government consultation: Termination of Pregnancy arrangements in Wales

The Royal Pharmaceutical Society (RPS) is the professional body for pharmacists in Great Britain. We are the only body that represents all sectors of pharmacy in Great Britain. The RPS leads and supports the development of the pharmacy profession including the advancement of science, practice, education and knowledge in pharmacy. In addition, we promote the profession's policies and views to a range of external stakeholders in a number of different forums.

Our response is based on the information available in the consultation. While we welcome in principle the change in routine practice outlined in the consultation, we ask that in order to protect patient safety that the service is regularly audited and reviewed, and that any safety incidents or any quality improvement needs are shared across Wales as part of a national approach.

1. **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**

We support the evidence showing that the temporary approval has had a positive impact on the provision of abortion services, providing effective, safe, and improved access to care. We are encouraged by:

- How the use of new technologies, including telemedicine, has resulted in a drop in average gestation and abortions being performed earlier than ever before. We are aware from recent DHSC data, that since the introduction of telemedicine, 30% of abortions now happen before 6 weeks' gestation, compared to only 13.5% in the same period in 2019.

- The results of a recent analysis of medical abortions which have showed shorter waiting times, earlier access and improved effectiveness for abortions conducted using a telemedicine-hybrid service than for those conducted in-person (footnote Lancet ref?).

- How telemedicine services have helped people to be seen on average 4.3 days earlier by virtual consultation. Increased flexibility and new access opportunities to services to support early termination of pregnancy would appear increase effectiveness by offering patients better control over the timing at which they took the medication.

- Evidence that shows significant adverse events are rare for women accessing the pills via a telemedicine service and clinical outcomes with telemedicine are equivalent to in-person care.

- The overall acceptability in the analysis of traditional vs telemedicine services which showed 96% approval, with 80% reporting a future preference for telemedicine.

- The reduction in the risk of women being confronted by anti-abortion protesters when attending a bricks and mortar clinic. These women often report being watched, observed, and being made the feel guilty. There have been multiple reports of women knowing a protester outside the clinic, compromising their privacy. Telemedicine therefore reduces the number of women exposed to this damaging activity.

- The added flexibility of the temporary approval for women and removal of barriers such as travelling long distances to a licenced clinic, taking time off work, and covering or paying for childcare.

While we support the positive impact of the temporary removal and the added flexibility for accessing services, we are cognisant that not all women and girls will have access to an electronic device in order to be able to undertake a remote consultation and there may be other barriers. We believe it is essential that people are given a choice of service provision to help overcome such barriers.

2. **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.**

Anecdotally, we have heard that staff involved in triaging patients consider that the service is continuing to be delivered to a high standard

Remote consulting enables greater workforce flexibility, for example, in cases of staff shielding and access to a wider pool of staff across a larger geographical area. It must however be considered that time, resources, and training are required to undertake video or telephone consultations, and this should continue to be available to those providing the service. The time spent in consultations with patients, whether provided in person or remotely, is likely to be similar.

3. **What risks do you consider are associated with the temporary measure? If you consider that there are risks, can these risks be mitigated?**

We would be concerned of the risk that people may access the service, under the temporary measure, when their pregnancy may potentially be over 10 weeks gestation. We appreciate this risk is very low but should be considered i.e. according to a large-scale analysis of abortion provision before and after the change in regulation, 0.04% of abortions appeared to have been provided at over 10 weeks' gestation. More recent assessments indicate that the risk within the BPAS service is lower, at around 1 in 3285. This is roughly 14 times lower than the risk of a pregnancy ending in stillbirth.

Mitigating this risk will require providers to have discussions with people in the same way as other kinds of risks and complications of abortion treatment. Healthcare professionals are the best people to determine what they need to discuss with their patients and will ensure all individuals have the relevant information to make an informed choice.

To mitigate the risks associated with medicine supply, the safe and effective use of medicines should underpin these arrangements. This includes mifepristone, misoprostol and analgesia, as well as anti-emetics, prophylactic antibiotics and ongoing contraception where used. Therefore, it is essential that all services have clear arrangements in place for confirming each medicine, including analgesia, is appropriate and safe for an individual patient. Where services are being provided remotely, remote access to clinical information and a discussion with the patient will be key components of confirming the safe use of medicines.

There are potential safeguarding and women's safety risks detailed in question 5.

4. **In your experience, have other NHS Wales services been affected by the temporary approval? If so, which?**

We are supportive of the data that suggests that the temporary approval has had a positive effect on other NHS Wales services. For instance, BPAS data from April – July 2020[1] shows that complications for Early Medical Abortions declined compared to the same period in 2019. The risk of continuing pregnancy after treatment fell by three-quarters to 0.28%, down from 1.12%, potentially as the result of women being able to choose the best time for them to start the procedure, rather than having to fit it around their commitments in addition to the in-clinic appointment for the first medication. The same data shows that the risk of major complication (usually the only kind of complication that need hospital care) fell by 2/3rds from 0.09% to 0.03% thereby reducing pressures on NHS Trusts.

Existing DHSC provisions ensure that independent abortion care providers provide follow-up care for women who access care with them. They have 24-hour aftercare phone line staffed by trained clinical staff, they provide in-clinic appointments for women with suspected incomplete abortions or retained products of conception, and they provide post-abortion counselling where a woman requires it. Telemedicine has not changed this. Uptake of pre and post counselling is low and has been provided via a telephone service prior to the telemedicine service being initiated.

We welcome the reduction in gestation which means more women can access early medical abortion, reducing the need for surgical services and releasing capacity for other medical procedures.

5. **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.**

We would advocate for patient- centred approach to the provision of abortion services where clients can choose their preferred method of service delivery. There must however be assurances that abortion services will continue to provide in-person care where people would prefer it or when telephone consultations raise potential safeguarding concerns such as safety or privacy at home, ability to consent, or wider safety concerns surrounding existing children or statutory concerns such as Female Genital Mutilation.

While we appreciate that safeguarding issues or coercion may be more difficult to detect via a remote, non-face to face, consultation, we are encouraged by anecdotal reports that providing care remotely for abortion has led to increases in the number of women disclosing problems at home. We are aware that BPAS has reported that in the first three months of their Pills by Post service, the number of clients completing enhanced safeguarding risk assessments increased.

Additionally, some women seeking access to services are in relationships or home environments where their behaviour and travel are monitored which means travelling to an abortion clinic is

difficult or dangerous. Telemedicine enables these women to access abortion care without risking their personal safety.

We believe considerations must be given to the method of virtual consultations. We note that the preferred option for women in one survey is for telephone consultation rather than video consultations yet some other services specifically recommend use of video consultations to reduce the risk of coercion (e.g., moving the camera to check who else is in the room with the patient). Where there are safeguarding issues that cannot be resolved remotely, women should be seen in person. The preference for use of telephone vs video consultations may need further research to mitigate against any safeguarding and coercion risks.

In addition, some women may find remote consultations impossible to access (e.g., lack of privacy at home for a remote consultation) and therefore alternative options should be available and we would advocate patient choice.

To ensure confidentiality is maintained the postal or courier delivery service needs to be robust.

6. **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?**

Based on the information available it is difficult to determine the impact on age (for example, younger women may have less privacy at home) and it is unclear if there is any impact on ethnicity or disability. Any changes made must be responsive to individual patient needs

Being able to remotely access services from the privacy of home may be especially significant for women in remote parts of Wales, since having to travel away from home to access care may be difficult to keep private in a small community. However, the ability to access urgent care should any adverse outcomes occur may be even more challenging in remote locations and therefore arrangements must be put in place for this before women in remote locations are supplied with medical abortion treatments as part of contingency plans.

Also essential to the safe use of medicines is women receiving clear information about how to take their medicine and when to seek further help. Information may need to be provided in multiple formats, recognising an individual woman's level of literacy, health literacy and languages spoken. Work should be undertaken with patient representative groups and health literacy experts to ensure information resources are fully accessible. In addition, consultations should be structured to confirm a patient's understanding of the information, especially as this may be more challenging in a remote consultation.

7. **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?**

By giving women more choice about how to access care this could have a positive impact on socio-economic equality. There is also a financial benefit by reducing the costs of travel to clinics and a reduced need to be absent from work.

However, some women may find remote consultations impossible to access and therefore alternative options must be available.

8. **Should the temporary measure enabling home use of both pills for EMA:**
   1. Become a permanent measure?
   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).
   3. Other [please provide details]?

Based on information available, it appears that women are well supported by the clinical specialists providing this service. The service appears to run well, and it provides quicker access and more choice for women. We believe, based on experience to date, it would be clinically appropriate to continue with the arrangements.

However, more evidence of the impact of the change to this service needs to be collated and shared before a permanent change is made. Any national guidelines that are in place should be regularly reviewed and changed as appropriate based on good practice or in response to a safety incident.

Abortion care should be evidence-based and reflect the best possible care available to women. Telemedicine is potentially able to provide up to date, high quality care going forward. Further research, particularly on acceptability, will be necessary post pandemic.

Consultation Response Form

Your name: ***[information redacted]***

Organisation (if applicable):Brook Young People

email / telephone number:

[information redacted]

Your address: ***[information redacted]***

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.** **Yes it has had a positive impact on safety, accessibility and convenience of services** **Safety** National evidence since the introduction of telemedicine abortion has shown that the temporary measure has had a positive impact on safety. A recent cohort study in England and Wales[i] compared the safety of 52,142 medical abortions (85% of all abortions that occurred during the study period) before and after the introduction of telemedicine services and found no differences in abortion completion rates or adverse events between abortions provided via telemedicine services and those provided in-person with routine ultrasound scanning. Mean waiting times were 4.2 days shorter in the telemedicine-hybrid cohort, and 40% were provided at ≤6 weeks' gestation compared to 25% in the traditional cohort, which will also improve the safety of services as earlier gestation abortions are known to have lower complication rates. Data from independent abortion provider BPAS from April-July 2020 shows that complications (continuing pregnancy) for early medical abortions were lower (0.28% vs 1.12%) than in the same period in 2019. This may be as a result of service-users choosing the most convenient time to start their abortion procedure rather than having a fixed window within which to take the second medication after the clinic visit International evidence has also proven the safety of offering medical abortion through telemedicine or remote models of care. A 2019 systematic review[ii] of published literature on telemedicine for abortion found telemedicine abortion to have outcome rates similar to in-person

care with similar very low rates of incomplete abortion, continuing pregnancy, or complications requiring hospital treatment

In 2019 NICE[iii] evidence-based guidelines advised that abortion could be provided safely without ultrasound in the absence of signs or symptoms of ectopic pregnancy.

Since 2018 the second abortion medication, misoprostol has been available to take at home. Before that though pills were taken in the clinic the abortion itself took place at home. Medical abortion can be managed safely and effectively at home.

There are additional ways in which telemedicine provision of EMA has had a positive impact on the safety of women and girls accessing abortion:

By removing the need for in-clinic visits, including sharing waiting rooms with multiple people, it has reduced the risk of Covid-19 infection on public transport and in the clinic itself.

It means that those who do need in-clinic visits are safer because less time is spent in waiting rooms with other people.

It has made access to abortion consultation and the abortion itself safer for those who do not have family support or would have been actively endangered by a family member or partner if they had needed to disclose their abortion (because of having to leave the home to travel to an in-clinic consultation and to collect pills).

Accessibility, convenience and acceptability

Data from the recently published cohort study demonstrates that waiting times for consultations were reduced by 4.2 days as a result of telemedicine consultations.

96% of women reported that the process was acceptable and 80% reported that they would support telemedicine provision of abortion in future.

It has allowed women and girls and all abortion-seekers to participate in consultations without the need to travel with associated risks and costs; and without taking significant time off from work, studies, childcare or other caring responsibilities – significantly increasing the convenience of the process, and maximising access by reducing many of the practical obstacles to access.

	Privacy and confidentiality For many women remote consultation and receiving pills by post has had a positive impact on confidentiality and privacy, allowing them to access services without having to disclose their intention to other household members, employers or education institutions as they might have had to if they had to access an in-clinic consultation. In a 2018 a study[iv] analysed the reasons given by 518 women in Britain who had attempted to purchase abortion pills by post via an online service Women on Web. Women described a range of barriers to access including concerns about privacy, perceived stigma, domestic violence and/or living with coercive or family control. Since telemedicine provision has been available in England requests for pills by post to the same provider have declined by 88% which is an indication that the new arrangements have removed those barriers to access. Those accessing abortion consultation and care at clinics have reported being exposed to harassment and infringement of their privacy by clinic protestors, approaching them, calling out to them and sometimes even filming them. For some people finding a private space at home for a telephone consultation or being reliant on borrowing someone else's phone may mean a visit to the clinic affords greater privacy. For this reason in-clinic consultations should be available as an option for anyone who needs one.

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.**

	Yes it has had a positive impact on provision of services for those involved in service delivery Doctors providing abortion services have reported a range of benefits of telemedicine provision. i) in terms of their own safety it has reduced the number of face to face consultations they have needed to carry out and helped protect them from unnecessary patient contact and Covid risk. ii) it has allowed some clinicians to work entirely remotely with no patient contact which has been beneficial for those clinicians in high-risk groups. iii) it has provided them with flexibility in service organisation including freeing up staff to relieve pressure in other parts of the health service to deal with Covid-19 iv) because the process has been streamlined it has freed up clinicians' time for those women and girls who need more time and support to evaluate their options, clarify their thoughts and confirm their decision to have an abortion. v) anecdotally clinicians have reported satisfaction with this arrangement and with the quality of service they have been able to provide

Q3.	**What risks do you consider are associated with the temporary measure? If you consider that there are risks, can these risks be mitigated?** Medical abortion under 10 weeks already routinely takes place at home. The key difference with the current arrangements is that the consultation takes place by phone and the pills are sent rather than collected from the clinic. So the abortion procedure itself is identical. The other difference is that ultrasound is not provided to date gestational age. This is in line with the 2019 NICE guideline on abortion, which recommends abortion can take place safely without routine use of ultrasound.

	Abortion care, NICE guideline [NG140]Published date: 25 September 2019 https://www.nice.org.uk/guidance/ng140/chapter/Recommendations#abortion-before-definitive-ultrasound-evidence-of-an-intrauterine-pregnancy [last accessed 22/02/2021 The national cohort study which analysed outcomes from 85% of all abortions provided by telemedicine abortion in England and Wales found a low rate of complications, none of which required hospital treatment. There are studies from around the world demonstrating the safety of telemedicine abortion provision. Endler M, Lavelanet, Cleeve A et al. Obstetrics and Gynaecology, 2019. Telemedicine for medical abortion: a systematic review https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.15684 [last accessed 22/02/2021] Anyone accessing telemedicine abortion is given clear information on what to expect, any symptoms that would require additional advice or treatment, and are given access to a 24 hour helpline in the event that they experience any problems. Anyone considered high risk is offered in-clinic consultation and care.

Q4.	**In your experience, have other NHS Wales services been affected by the temporary approval? If so, which?**

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.** For the vast majority of those seeking early medical abortion there are no benefits to making a clinic visit for an assessment by a clinician or to collect medication. The remote consultation process includes a safeguarding assessment. An in-clinic appointment can be arranged in the event that a clinician believes it would be beneficial for clinical safety or other safeguarding reasons. In most cases it will not be necessary nor beneficial. After the pandemic is over offering a clinic visit to those who choose one would be beneficial. For some people, for example with easy access to a clinic, or with difficulty finding private space at home or work for a consultation, it may be *preferable* and therefore should remain an option.

	Given the 96% acceptability of telemedicine abortion reported by service-users in the recent cohort study, and 80% reporting that they would prefer telemedicine in future, it is likely that the vast majority of future service-users would opt for remote consultations and pills by post. Therefore most women would be disadvantaged by reintroducing a routine or mandatory clinic visit.

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?** For the small number of transmen and non-binary people seeking abortion the ability to avoid visits to abortion clinics would be extremely beneficial ensuring that their gender presentation in-clinics largely set up for female patients does not add unnecessary stress to the experiencing of accessing abortion. Disabled people who are reliant on carers and reliant on private transport, are likely to incur additional inconvenience and costs in accessing in-clinic consultations. Women, especially young women, in families or communities in which abortion is highly stigmatised, including some minority communities, may find it harder or more risky to disclose their abortion decision to others. In these cases, the added privacy and confidentiality of being able to access abortion by telemedicine, combined with self-referral mechanisms that avoid the need to visit the GP are highly beneficial and any unnecessary in-clinic visit could present safeguarding issues for them.

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?** Any routine need to travel to in-clinic appointments for abortion care disadvantages women from more deprived backgrounds and especially those in rural areas or small towns without private transport who may need to travel significant distances to reach a clinic. Young women, particularly are likely to have fewer resources and less access to private transport.

Q8.	**Should the temporary measure enabling home use of both pills for EMA:** **1. Become a permanent measure?** **Brook fully supports the permanent introduction of telemedicine abortion which is safe, acceptable, effective, cost-effective and improves accessibility for all.** Comprehensive data from the national cohort study published in February 2021 concludes that a telemedicine-hybrid model for medical abortion that includes no-test telemedicine and treatment without an ultrasound is effective, safe, acceptable, and improves access to care. The study found that waiting times were reduced by 4.2 days, and 40% of abortions were provided at six weeks or earlier compared to 25% in the comparison period. Effectiveness was higher than telemedicine with in-person care, and acceptability of telemedicine was high (96%). For a range of different groups of women the option of telemedicine consultation with provision of pills by post is beneficial: Young women without family support who may ordinarily find it hard to explain their absence from home or school to attend in-clinic visits, and who are most likely to have limited resources to pay for travel and no private transport. Other women in insecure jobs and/or low income who may find it financially difficult to take time off work and/or pay for the travel costs of attending in-clinic visits. Women with children who may find it difficult to arrange and pay for childcare while attending in-clinic visits.

	Women in rural areas who are likely to have to travel significantly further than those in big towns and cities to attend in-clinic visits, which can be difficult for those with no access to private transport for reasons of cost and logistics. Women with disabilities who may find travel difficult even in large towns and cities. Women experiencing domestic violence or coercive control who find it difficult to leave their homes without the cooperation or their partner. For the small number of transmen and non-binary people seeking abortion the ability to avoid visits to abortion clinics would be extremely beneficial ensuring that their gender presentation in-clinics largely set up for female patients did not add unnecessary stress to the experiencing of accessing abortion. Finally, we strongly recommend that the option of in-clinic consultation remains available for those who prefer or need it. We are also aware that for some women early surgical abortion is a more suitable option and would urge commissioners and providers to ensure that this option remains available and does not become less accessible because of the success of the telemedicine abortion model. It is important that choice of abortion method is maintained.

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:

[i] Aiken A, Lohr PA, Lord J et al, Obstetrics and Gynaecology 2021. Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.16668[last accessed 22/02/2021]

[ii] Endler M, Lavelanet, Cleeve A et al. Obstetrics and Gynaecology, 2019. Telemedicine for medical abortion: a systematic review https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.15684 [last accessed 22/02/2021]

iii Abortion care, NICE guideline [NG140]Published date: 25 September 2019 https://www.nice.org.uk/guidance/ng140/chapter/Recommendations#abortion-before-definitive-ultrasound-evidence-of-an-intrauterine-pregnancy [last accessed 22/02/2021

[iv] Aiken A, Guthrie K et al. Contraception, 2018. Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain. https://www.sciencedirect.com/science/article/abs/pii/S0010782417304353 [last accessed 22/02/21]

Telemedicine and abortion during Covid-19 in Betsi Cadwaladr UHB and Powys THB

Response to the Deputy Chief Medical Officer in Wales

Overview

The change in regulation to enable BPAS to provide telemedical abortion services to clients in the early stages of their pregnancy was essential during lockdown and is necessary to provide accessible, safe, and effective abortion care in future.

It is supported by clinicians, regulators, providers, and women. Of those BPAS clients who received Pills by Post who expressed a preference in follow-up surveys, more than 80% would choose the same method again.

This decision should be grounded not in politics or public opinion, but on the clinical assessment of how to provide legal, effective medical care.

Providing abortion care in Wales

In Wales, BPAS is responsible for providing care in two of the most rural health boards – Betsi Cadwaladr and Powys - where women are often required to travel up to an hour each way to access abortion care even at the earliest gestations. We are also contracted by a number of other Health Boards to provide care for women up to the legal limit of 24 weeks' gestation.

With a large number of remote rural communities and the time-limited nature of abortion care, additional barriers such as limited access to private transport; the need to arrange childcare; or the ability to take time off work, can make accessing abortion care in-clinic a daunting prospect.

Given the requirements of the Abortion Act, it is simply not possible to provide care closer to home in a situation where women are required to attend a licensed premise. As a result, telemedical abortion services are the only way to ensure that abortion care is truly accessible.

Abortion care fit for the future

Before this latest change facilitating telemedical abortion, it was already legal for misoprostol, the second of two medicines used in Early Medical Abortion (EMA), to be administered at home up to 9^{+6} weeks. As a result, more than 5,000 women in Wales each year self-managed their abortion at home – but were required by the law to attend a clinic to take one pill.

The law has also never required women to have a scan, and clinical guidelines make clear that routine scanning is unnecessary.

No matter the change in regulation around the location where a woman can administer the first pill in an EMA, BPAS had already started to move towards scanning only as indicated as a service improvement prior to the COVID-19 pandemic.

BPAS will not be reverting to routine scanning, which is not clinically indicated, can be invasive (particularly if transvaginal, as is often the case in early pregnancy), and physically and emotionally challenging for clients.

The only aspect of this care that sits with government is where a client administers the pills – not how medical care is provided.

Provision during lockdown

During the first quarter of provision of the BPAS telemedical service Pills by Post, we treated 722 women from Betsi Cadwaladr and Powys. 507 of these clients (70%) received Pills by Post, and 120 more received an EMA after visiting one of our clinics in Llandudno, Cardiff, and Chester.

(Q 08/04 to 07/07) Betsi and Powys clients	2020	2019	Change
Total procedures	722	549	+32%
Of which % EMA	86.84%	70.49%	+16.35pp

We provided a further 15 EMA services to women from other health boards, and 50 surgical procedures beyond 10 weeks' gestation at our clinic in Cardiff, and for women beyond their local health board's gestational limit but still prior to the 24-week legal limit, at our clinics in Bournemouth and Richmond (London).

Waiting times

The shift to telemedicine has resulted in a sizeable and sustained decrease in waiting times. This is, in part, a result of teleconsultations not being limited to the days a physical clinic is running (e.g. BPAS Welshpool only runs clinics on Friday because of levels of local demand), and partly as a result of increased, adjustable resource which means that teleconsultations can be provided by elsewhere in the country if waiting times begin to increase in one area.

Across all providers, waiting times for surgical procedures are higher than EMA as a result of the need to run and fill surgical lists, the reduced number of procedures performed, and the smaller number of centres that provide more complex, later treatment. RCOG and NICE guidance recommend that treatment occurs within 14 days of first contact.

(Q 08/04 to 07/07) Betsi and Powys clients	2020	2019	Change
Waiting time first contact to treatment (days)	7	20	-13
Waiting time first contact to treatment (EMA) (days)	5	16	-11

Gestational age

Gestational age has reduced across the BPAS service and all other providers of which we are aware – partly as a result of the reduction in waiting times, and partly as a result of women not being forced to delay appointments because they are unable to secure childcare, time off work, or travel to a clinic.

Reducing gestational age is essential to improving outcomes. Although the risks of complications of abortion are always low (and in all instances, lower than continuing a pregnancy to term), the earlier the procedure is performed the better for a woman's mental and physical health. After 8 weeks' gestation, the risks related to abortion rise exponentially with each additional week of gestation.

(Q 08/04 to 07/07) Betsi and Powys clients	2020	2019	Change (days)
Gestational age (weeks)	7^{+4}	9^{+0}	-10
Gestational age (EMA) (weeks)	6^{+5}	7^{+4}	-6

Awareness of negative outcomes

Since the change in clinical practice to rely on Last Menstrual Period (LMP) rather than a scan for determining gestational age, there have been a very small number of cases across NHS

and Independent Sector services involving gestations outside the 10-week limit for pills at home. The risk of such occurrences is very low – currently around 1 in 2,500 women treated. Simply put, in order to avert a case of a woman using this treatment at a gestation of more than 10 weeks, 2,500 women would be required to attend a clinic to be scanned with associated delays to accessing care, thereby increasing the gestational age and potential for complications.

There has been one incident in Wales falling into this category which resulted in a continuing pregnancy.

BPAS has conducted a full Serious Incident Requiring Investigation (SIRI) review of such incidents in our service, and has made improvements to our LMP determination and initial assessment as a result of learning from these cases.

BPAS has also encountered a very small number of ectopic pregnancies subsequent to treatment. In the first two months of Pills by Post, this amounted to 8 ectopic pregnancies out of 13,081 medical abortion treatments provided (around 1 in 1650). Six of these cases were identified promptly by BPAS aftercare and two presented directly for NHS care.

We can confirm that as of September 2020, there have been no maternal deaths linked to telemedical abortion services – any such reports are based on false information.

Feedback from BPAS providers in Wales

"Since telemedicine has been introduced, we are able to meet the needs of our clients more efficiently as wait times are greatly reduced.

The service is less susceptible to disruption as, for example, my nurse had to quarantine and was able to work from home with no detriment to the clients. Powys clinic had to close due to the hospital restricting clinics, due to Covid, but we were able to maintain the service by completing the telecons from Llandudno. We have clients who have been unable to leave their homes due to shielding who have been ever so grateful to receive the pills at home. Clients who have found it difficult to travel, for lots of reasons, have also really appreciated the offer of telemedicine."

- Treatment Unit Manager, BPAS Llandudno and BPAS Powys

"In Cardiff we have definitely seen more women coming for EMA rather than surgical TOP (Termination of Pregnancy) because access has been much quicker and easier. Women have not had to arrange childcare to visit a clinic, women can deal with their termination how they wish to and they have told us that they have not had to involve family members which ordinarily they would have had to. They take the meds at a time convenient to them and their families and lifestyle.

In Cardiff we offer post-op appointments every day we are open and we thought we would see a surge in uptake of these as we thought women may be worried as to whether the TOP had worked, but we have had less uptake of ladies coming in for post op. We do receive a higher volume of calls with women just wanting re assurance that their experience of EMA is normal.

It has been a wholly positive experience for the women of Wales particularly because a lot of women don't like leaving their rural homes and coming into the city, it made the whole process more traumatic for them. It has empowered women and I believe that not having to involve wider family members to be able to access TOP has been a real game changer."

- Treatment Unit Manager, BPAS Cardiff

Y Gymdeithas Feddygol Brydeinig
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Women and Children's Health Branch
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22 February 2021

Welsh Government consultation: Termination of Pregnancy arrangements in Wales
Response by BMA Cymru Wales

Introduction

BMA Cymru Wales is pleased to provide a response to the consultation by the Welsh Government on regarding the termination of pregnancy arrangements in Wales.

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

Response

1. 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.

We believe it has had a positive impact. Data show that remote early medical abortion (EMA) provision, for eligible women, is both safe and effective. Remote provision has been shown to reduce waiting times, enabling abortion to take place at an earlier stage of pregnancy which is known to be safer. Remote EMA also improves accessibility for eligible women.

[information redacted]

This is also the view held by the main clinical bodies responsible for abortion care - the Royal College of Obstetricians and Gynaecologists (RCOG) and the Faculty of Sexual and Reproductive Healthcare (FSRH).

They also state that *'…while many healthcare services have paused during the pandemic, access to abortion has been not only maintained but improved through the innovative use of telemedicine. This has reduced unnecessary visits to clinics and increased the safety of abortion care.'*

As is currently the case, where there are additional considerations that may affect the safety of remote EMA, there will continue to be a need for face-to-face services for some patients. This is already provided for in the RCOG, Royal College of Midwives (RCM), FSRH and the British Society of Abortion Care Providers (BSACP) clinical guidelines that cover remote EMA, *Coronavirus (COVID-19) infection and abortion care*.

- *Safer - reducing waiting times and consequently average gestation for EMA*

The earlier that an abortion is conducted, the safer it is - this is acknowledged in the consultation document itself 'Accessing EMA services rather than abortion later in pregnancy helps to reduce the risk of complications, which increases the later the gestation**'**.

The UK government published 'provisional' statistics on abortions performed in England and Wales during the COVID-19 pandemic from January to June 2020 (only for residents of England and Wales), which show that:

- 86% of abortions were performed at under 10 weeks compared with 81% during the same period in 2019.
- 50% of abortions were performed before 7 weeks' gestation compared to almost 40% for the same period in 2019.

No explanation for the reduction in the average gestation is given within the published statistics.

In addition, however, a study comparing outcomes before and after the implementation of the telemedicine-hybrid model of delivering EMA, using data from the three main abortion providers[1], show that the mean waiting time from referral to treatment was 4.2 days shorter in the telemedicine-hybrid model and more abortions were provided at ≤6 weeks' gestation (40% vs. 25%, $p<0.001$).

[1] Aiken, A., Lohr, P.A., Lord, J., Ghosh, N. and Starling, J. (2021), Effectiveness, safety and acceptability of no - test medical abortion provided via telemedicine: a national cohort study. BJOG: Int J Obstet Gy. Accepted Author Manuscript. https://doi.org/10.1111/1471-0528.16668 (https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.16668)

Following the publication of 'provisional' statistics by the UK government, two of the main abortion providers in England, MSI Reproductive Choices (formerly known as Marie Stopes) and BPAS, released some of the data from their services showing that:

- MSI Reproductive Choices: 'Waiting times have significantly reduced, with almost half of patients (46%) able to have a detailed consultation with a clinician within one day, compared with 9% of non-telemedicine clients.'; and '56% of women [were] having their telemedicine abortion before 6 weeks compared to 37% previously. Lower gestational age reduces the already low complication rate of early medical abortion to 2.5%. Complications include retained products of conception (1.5%) and failed termination of pregnancy rate (1.0%) which can be treated by minor, planned procedures.' (MSI Reproductive Choices UK press statement. *10.09.20: Abortion Statistics for England and Wales during the COVID-19 pandemic*).

- BPAS: '…waiting times for appointments have more than halved, with an average wait for an appointment of just 4 days. The average gestation at which women have their consultation has also fallen by over a week, from 60 days in the first half of 2019, compared with 52 days during the same period in 2020.' (BPAS press statement 11.09.20: *Comment on DHSC Abortion Statistics: Telemedical abortion service results in significant drop in gestation at which women can access care – protecting their health during the pandemic)*

- *Safer - supporting better access to regulated services*

For a range of logistical, social and economic reasons, individuals may illegally access abortifacients from unregulated suppliers, without the safety of knowing whether the drugs they receive are licensed and are what they claim to be.

The BMA has received feedback from doctors that they believe that some women who may have previously accessed abortifacients from unregulated suppliers are now accessing regulated safer abortions due to remote EMA provision.

This was recently highlighted by the English and Welsh Court of Appeal in the judicial review *R (on the Application of Christian Concern) v Secretary of State for Health And Social Care* [2020] EWCA Civ 1239. In the judgment it noted evidence *'... which identify the risks to patients who were seeking EMAs in terms of their health and wider vulnerability ... vulnerable individuals were having to seek help from online providers, outside the regulated healthcare system, thereby breaking the law and losing the safeguarding and support inherent in the process provided by regulated services*' (at 48 of the judgment).

- *International*

Albeit not in the UK, remote EMA was already a tried and tested model for safe delivery of aspects of abortion services elsewhere.

The temporary approvals were introduced with the benefit of having patient outcome data from other countries which provided some form of remote provision of EMA prior to the pandemic - for example, Australia and some states in the USA.

In addition, on the role of patients self-managing the process for medical abortion, the World Health Organization's (WHO) 2015 evidence-based guideline *Health worker roles in providing safe abortion care and post-abortion contraception* [2] recommends that, where individuals have a source of accurate information and access to a health-care provider should they need or want it at any stage of the process, they can:

- safely and effectively self-manage mifepristone and misoprostol medication without direct supervision of a health-care provider.
- self-assess completeness of the abortion process using pregnancy tests and checklists.

The WHO guideline notes that '*Such self-assessment and self-management approaches can be empowering for women and help to triage care, leading to a more optimal use of health resources*.'

- *Accessibility*

Remote EMA improves accessibility for eligible patients. This was already recognised prior to the COVID pandemic. Separate to the actual treatment, aspects of abortion care could already be delivered remotely and were promoted by NICE as improving access to services.

The 2019 NICE guideline on abortion care notes, for example:

- *'1.1.9 Consider providing abortion assessments by phone or video call, for women who prefer this.' [On this, NICE found 'Community services and telemedicine appointments are recommended because the evidence showed they improve access to abortion services. There was also limited evidence that patient satisfaction is the same with abortions provided by community or by hospital services, and with appointments provided via telemedicine or at the hospital' (page 28)]; and*
- *'1.14.1 For women who have had a medical abortion up to and including 10+0 weeks' gestation with expulsion at home, offer the choice of self-assessment, including remote assessment (for example telephone or text messaging), as an alternative to clinic follow-up.' [On this, NICE found 'Limited evidence was available showing no clinically important difference between remote and clinic follow-up for rates of adherence to follow-up.' And 'There was only very limited indirect evidence on patient satisfaction, suggesting a preference for remote over clinic follow-up.'* (page 50)].

The benefits have been recognised by the clinical experts in the UK and also internationally. At the end of September 2020 the International Federation of Gynecology and Obstetrics (FIGO) called for the strengthening of access to telemedicine/self-managed abortion recognising that telemedicine is an effective tool that '*can ensure women and girls have access to safe, non-judgmental abortion services at all time[s]*'.

[2] [2] WHO (2015) *Health worker roles in providing safe abortion care and post-abortion contraception* https://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf;jsessionid=154A2A05AC7427FB50EA554D1F5F3F78?sequence=1

- *Patient satisfaction*

In addition to safety and accessibility, patients' views of remote EMA should be considered, although likely to be affected by these other factors.

A study comparing outcomes before and after the implementation of the telemedicine-hybrid model of delivering EMA using data from the three main abortion providers in England[3], shows that acceptability of telemedicine was high (96% satisfied) and 80% reported a future preference for telemedicine.

This chimes with other published data and feedback that the Welsh government has received from Chief Executives of health boards '*All have reported...very positive feedback from patients using this model of care*.' (pages 6-7 of the consultation document). For example**,** MSI Reproductive Choices found that '*98% of clients surveyed rat[ed] their experience as good or very good and 99.9%[5] of clients report[ed] they had adequate privacy'***.** Additional data from MSI found that '*Patients reported high confidence in telemedicine EMA and high satisfaction with the convenience, privacy and ease of managing their abortion at home. No patient reported that they were unable to consult privately. The majority (1035, 83%) of patients reported preferring the telemedicine pathway, with 824 (66%) indicating that they would choose telemedicine again if COVID-19 were no longer an issue..'*[4]

- *Access – intimidation and harassment outside services*

Remote access to EMA may also be more desirable and improve access for some patients who may be deterred from accessing healthcare due to anti-abortion demonstrations outside services. For example, ongoing activity outside Cardiff BPAS (https://back-off.org/recorded-protests/). Remote EMA is not, however, the solution to this problem, particularly as some women will still need to access services in person. We would be interested to hear what steps the Welsh Government is taking to address the issue of intimidation and harassment outside services as local responses are not adequate. The BMA believes that this issue needs addressing at a national level with the introduction of exclusion zones outside confidential abortion services. Only then can it be ensured that the harassment and intimidation can be stopped swiftly and straightforwardly, and no individual accessing services has to experience being filmed, shouted at, feel unsafe or be fearful and deterred from accessing healthcare.

2. 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

[3] Aiken, A., Lohr, P.A., Lord, J., Ghosh, N. and Starling, J. (2021), *Effectiveness, safety and acceptability of no - test medical abortion provided via telemedicine: a national cohort study.* BJOG: Int J Obstet Gy. Accepted Author Manuscript. https://doi.org/10.1111/1471-0528.16668 (https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.16668)

[4] Porter Erlank C, Lord J, Church K. *Acceptability of no-test medical abortion provided via telemedicine: analysis of patient-reported outcomes* BMJ Sexual & Reproductive Health Published Online First: 18 February 2021. doi: 10.1136/bmjsrh-2020-200954 (https://srh.bmj.com/content/early/2021/02/17/bmjsrh-2020-200954)

might include greater workforce flexibility, efficiency of service delivery, value for money etc. Please provide your reasons.

We believe it has had a positive impact. The BMA has heard positive feedback from doctors who provide abortion services on the impact of remote EMA, primarily in the context of being able to provide choice and timely access to services for patients.

- *Workforce flexibility*

In addition, we have also received reports from our members that the temporary measures have enabled some doctors to continue working when they might not otherwise have been able to.

Many of the current doctors providing EMA have caring responsibilities and the ability to work from home allows for greater flexibility. For example, due to working time constraints as a consequence of opening hours of nurseries and schools and limited wrap around childcare.

Being able to provide remote EMA also helps in the retainment and recruitment of staff who may find it difficult to be in the clinical setting due to health reasons; logistical barriers such as long and costly commutes; work-life balance; and competing NHS commitments at other clinical sites.

Workforce flexibility broadens the group of doctors able to work for the service. Enabling doctors to provide some EMA remotely, and potentially over much larger geographical areas, will support much needed service efficiency, critical in the context of 'dwindling numbers of NHS healthcare professionals taking part in abortion care'.[6]

The British Society of Abortion Care Providers (BSACP) notes in its position statement on remote consultations '*Overall, studies on telemedicine in all its permutations and across settings are reassuring … with respect to safety, complications and acceptability to patients and providers*.' (The BSACP is a multi-professional organisation formed to promote, amongst other things, best practice and research in abortion care.)

- *Efficiency of service delivery*

Service providers will be best placed to respond on the efficiency of service delivery. Of note, however, a study comparing outcomes before and after the implementation of the telemedicine-hybrid model of delivering EMA [5] shows that within the telemedicine-hybrid model, effectiveness was higher with telemedicine than in-person care (99.2% vs. 98.1%, $p<0.001$).

- *Value for money*

[5] Aiken, A., Lohr, P.A., Lord, J., Ghosh, N. and Starling, J. (2021), Effectiveness, safety and acceptability of no - test medical abortion provided via telemedicine: a national cohort study. BJOG: Int J Obstet Gy. Accepted Author Manuscript. https://doi.org/10.1111/1471-0528.16668 (https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.16668)

As noted previously, the introduction of remote EMA has brought down the average gestational age for an abortion. This potentially has financial implications as more patients may fall below certain gestational thresholds for treatment options. For example, prior to this, the 2019 NICE review of NHS workforce and resource impacts noted:

- *'A reduction in waiting times for an abortion. This will result in fewer surgical abortions overall and a corresponding increase in earlier medical abortions which have a lower tariff.*
- *'An increase in earlier medical terminations may also lead to a reduction in outpatient appointments and diagnostic tests.*
- *'A reduction in the number of women having rhesus status testing and anti-D prophylaxis.*
- *A reduction in the number of ultrasound scans.'*

3. What risks do you consider are associated with the temporary measure? If you consider that there are risks, can these risks be mitigated?

We are aware of several concerns about possible risks that have been raised since the implementation of the temporary provisions in England, Wales and Scotland. There have, for example, been tens of questions raised in the Westminster parliament since the remote provision was introduced, including questions on accurately establishing gestation and other safety concerns.

There have been some erroneous and factually incorrect reports of maternal deaths associated with the remote provision of EMA in England. The UK government, the RCOG and CQC have, however, confirmed that there have been no maternal deaths as a consequence of remote provision.

We agree with the comment in the consultation document '*We are confident that all clinical and safeguarding risks are being considered and managed appropriately including the assessment of gestation*.'

Abortion care is delivered within tights parameters outlined by law, regulation, clinical and professional standards. These are the same whether the service is delivered face- to-face or remotely – for example, the same standards regarding consent and safeguarding apply.

Of note, for example, on accurately dating a pregnancy, the RCOG, RCM, FSRH and BSACP abortion COVID guidance states:

- *'Most women can determine the gestational age of their pregnancy with reasonable accuracy by LMP alone. A prospective trial of 4,484 women seeking early medical abortion found that 1.2% of women whose LMP dated them to less than 10 weeks had ultrasound dating of over 10 weeks. Inadvertent treatment of gestations over 10 weeks is inevitable in some women, although the consequences for most are unlikely to be significant*

Underestimation of gestational age could result in a failure of the abortion (the likelihood of which may be mitigated by offering additional doses of misoprostol – see section 2.4), and bleeding, cramping and distress being greater than expected. After 9 weeks, the products of the pregnancy may be more visible at the time of the abortion. Nevertheless, the overall success of self-managed abortions by women at >12 to 24 weeks' gestation is 93%, with efficacy and safety similar to that expected in earlier gestation.' (page 12)

- *'Where uncertainty exists, other factors in the woman's history may help to determine whether a scan ought to be discussed and considered – for example the timing of pregnancy testing and onset of pregnancy symptoms, dates that contraceptive pills were missed or when intercourse occurred.' (page 13)*
- *'There is no requirement for an ultrasound to determine gestation age in order for a doctor to authorise an abortion under the requirements of the Abortion Act 1967. There should be no legal consequences for either the clinician or the woman, even if gestation is unexpectedly advanced, when they can demonstrate that they have acted 'in good faith'. Data from the first 6 weeks of telemedicine suggests that the risk of inadvertently treating late gestations is low but given the high volume of cases, even low event rates will occur. It should be noted that terminations of pregnancy (of any gestation) carried out within the law are not subject to a child death review.' (page 13)*

- *The risks of not continuing to provide remote EMA*

The emphasis of this consultation is on the impact and/or risks of continuing this provision. Given the clear steer from clinical bodies directly involved in the provision of remote EMA that it is safe, there are no increased serious adverse events, and it should continue, it may be helpful to reframe the consultation and consider instead what the risks are of not providing a remote EMA service..

4. In your experience, have other NHS Wales services been affected by the temporary approval? If so, which?

We are not aware of other NHS services being affected.

In terms of data on adverse events, there is nothing to suggest an additional burden on other NHS services. A study comparing outcomes before and after the implementation of the telemedicine-hybrid model of delivering EMA [6] shows that treatment success (98.8% vs. 98.2%, p>0.999), serious adverse events (0.02% vs. 0.04%, p=0.557), and incidence of ectopic pregnancy (0.2% vs. 0.2%, p=0.796) were not different between models.

Considering this more widely, the World Health Organization's (WHO) 2015 evidence-based guideline *Health worker roles in providing safe abortion care and post-abortion*

[6] Aiken, A., Lohr, P.A., Lord, J., Ghosh, N. and Starling, J. (2021), Effectiveness, safety and acceptability of no - test medical abortion provided via telemedicine: a national cohort study. BJOG: Int J Obstet Gy. Accepted Author Manuscript. https://doi.org/10.1111/1471-0528.16668 (https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.16668)

contraception[7] notes that '*Such self-assessment and self-management approaches can be empowering for women and help to triage care, leading to a more optimal use of health resources.'*

5. 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.

It is important that abortion services are able to identify, support and safeguard patients who are at risk. This is possible via telemedicine and via physical appointments.

A blanket requirement for patients to make at least one visit to a service may prevent some who are at risk from accessing regulated safe abortion services and safeguarding support – as was recently highlighted in the judicial review *R (on the Application of Christian Concern) v Secretary of State for Health And Social Care* [2020] EWCA Civ 1239 *'...vulnerable women were having to seek help from online providers, outside the regulated healthcare system, thereby breaking the law and losing the safeguarding and support inherent in the process provided by regulated services'* (at 48 of the judgment).

The RCOG, RCM, FSRH and BSACP guidance notes:

- *'It is not known how many women access unregulated sources of abortion medication in the UK, but pathway modifications, following the approval of early medical abortion at home, make it likely this group will now access care through abortion care providers. The benefits of such vulnerable women engaging with abortion care providers are significant – the safeguarding processes may detect inaccurate dating of last menstrual period (LMP) and could identify victims of abuse who would otherwise have gone undetected'(pages 8-9).*

And later:

- '*Safeguarding is an essential part of the assessment for abortion care, and providers should follow their processes and assess each case on an individual basis. However, there is no automatic need to have to do this in person if adequate assessment is possible via remote consultation, although it is recommended that this should be tailored to the individual. The clinician should be confident that the woman is not being coerced and that she is able to discuss any concerns privately. Remote consultation may enable vulnerable women, for example those with a coercive partner, to access care more discreetly, especially during COVID-19 and lockdown' (page 24).*

MSI Reproductive Choices data on this found that they had seen '...a 77% increase in the number of safeguarding cases identified, meaning more protection for vulnerable women and girls who can now access help in private without the need to inform a

[7] WHO (2015) *Health worker roles in providing safe abortion care and post-abortion contraception* https://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf;jsessionid=154A2A05AC7427FB50EA554D1F5F3F78?sequence=1

coercive partner or divulge intimate details to family.' They also '*found safeguarding via telemedicine using a telephone or video consultation to be highly effective, as women and girls who are too frightened to attend consultations in person can talk more openly and privately. Safeguarding concerns identified have increased by 77% during the first six months of the COVID-19 pandemic and include major safeguarding cases such as a 12-year-old being subject to rape by two relatives*.'

BPAS has also reported that in the first three months of their **Pills by Post service**, 10% of clients underwent an enhanced safeguarding risk assessment – a 12% increase compared to March 2020.

6. 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?

We are aware of work currently being considered by the University of Liverpool to evaluate the positive and negative equity impacts of COVID-19 policy changes on access to EMA in England and Wales. If this work progresses, there may be insights which can be considered.

As alluded to elsewhere in our response, due to a range of logistical, social and economic reasons, women can find it challenging to access lawful abortion services: for example, for health reasons, juggling work and/or childcare commitments to attend appointments, and/or paying for travel if services are far away.

Current arrangements should not result in abortion services being delivered remotely exclusively – there will still be a need for face-to-face services where women and girls choose this or need them due to clinical and/or social factors - but any developments that broaden access to services should be welcomed and enhance access for different groups of women

7. 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?

Continuing the provision of remote EMA after the pandemic will help ensure that individuals from more deprived backgrounds, or between geographical areas with different levels of disadvantage, are able to continue to access safe lawful abortion services.

As Evidence Review A for the 2019 NICE guideline on abortion care notes:

> *'The committee agreed that the recommendations made (particularly those related to location of services, making it easier to access services and comorbid medical conditions) have the potential to reduce current inequalities in accessing abortion services for the following groups by improving referral pathways, minimising travel and decreasing the number of appointments that women need to attend in person: women living in remote areas, women with low income, women with comorbid physical and/or mental health problems, vulnerable women, and girls and younger women.'* (page 46)

A recent study comparing the different responses by European countries to providing abortion in the pandemic notes '*some innovations including telemedicine deployedduring the outbreak could serve as a catalyst to ensure continuity and equity of abortioncare*'[8]

8. Should the temporary measure enabling home use of both pills for EMA:
   1. Become a permanent measure?
   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).
   3. Other [please provide details]?

The BMA supports making these temporary changes permanent so that eligible individuals who choose can continue to access EMA remotely after the COVID-19 pandemic. This position was formally adopted at the BMA's annual representative meeting (ARM) in September 2020 when the benefits and risks of continuing current arrangements were debated by the BMA's policy-making representative body.

Remote EMAs should become a permanent option where clinically appropriate. They reduce waiting times, allowing abortions to take place at an earlier stage of pregnancy, which is safer; they improve access; and patients report high levels of patient satisfaction.

It is the BMA's view that continuation of this arrangement is in line with best global practice and benefits patients, particularly those at risk of domestic violence.

We believe that this view is also supported by the feedback that Welsh Government officials have received from Chief Executives of health boards 'All have reported improved outcomes in a number of areas including shorter waiting times, increased numbers of abortions taking place at a lower gestation and, significantly, very positive feedback from patients using this model of care. There have also been positive outcomes in terms of better use of resources and cost effectiveness' (pages 6-7 of the consultation document).

[8] (Moreau C, Shankar M, Glasier A, et al. Abortion regulation in Europe in the era of COVID-19: a spectrum of policy responses. BMJ Sexual & Reproductive Health. Available at https://srh.bmj.com/content/early/2021/01/13/bmjsrh-2020-200724).

Background

About us

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

We are contracted to provide NHS-funded abortion services to women living in Betsi Cadwaladr University Health Board and Powys Teaching Health Board, and provide services later on in pregnancy to women from all parts of Wales via our clinics in Cardiff and England.

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

Covid-19

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

Clinical guidance

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

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

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

Changes to licensed premises

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

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

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

The consultation

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

The BPAS service

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

BPAS's Pills by Post service consists of:

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

The BPAS position

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

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

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

Consultation response

Impact on provision

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.

BPAS believes that the temporary approval has had a significant positive impact on the provision of abortion services. Abortion remains safe, effective, and more accessible and convenient than ever before. This is particularly true for women who may have work or caring commitments, or who may not have access to private transport.

As members of the Welsh group of the British Society of Abortion Care Providers and the Secretariat to the Welsh Senedd's Cross-Party Group on Women's Health, we have heard from abortion providers across Wales who report that this change has been 'revolutionary' to their services – enabling them to drastically reduce waiting times, minimise the need for repeat visits or referrals via other care, and reduce the gestational age at which abortions are provided.

Safety – positive impact

Although no medical procedure is without risk, abortion is a safe procedure and, in all instances, safer than continuing the pregnancy to term. Early Medical Abortion is a safe regimen that has been routinely used in Wales and throughout the UK for hundreds of thousands of women for nearly 30 years.

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

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

The study found that there were no differences in success rates between the two groups (98.2% vs 98.8%) and no differences in the prevalence of serious adverse events (0.04% vs 0.02%). The incidence of ectopic pregnancy was equivalent in both cohorts (0.2%), with no difference in the proportions being treated after abortion (0.01% vs 0.03%). In the telemedicine-hybrid group, the effectiveness for abortions conducted using telemedicine was 99.2% compared with 98.1% in the traditional group.

In 0.04% of cases after the change in regulation, the abortion appeared to have been provided at over 10 weeks' gestation; these abortions were all completed at home without additional medical complications. This is 25 times lower than the percentage of pregnancies which end in miscarriage in the second trimester (12-24 weeks).

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

and minimising the risk to those women who are clinically vulnerable.

Accessibility and convenience – positive impact

We know that for many women, being required to take medication in a clinic is difficult. Clinics can be far from a client's home, they need to take time off work, associated travel and childcare costs can be high, appointments can be lengthy because of the legal requirement for two doctors to authorise the abortion, and because of the requirement to take mifepristone in-clinic and the second set of pills 24-48 hours later, a woman cannot choose when she passes her pregnancy. These difficulties are particularly acute for women in more rural and remote parts of Wales, including North Wales where BPAS provides NHS-funded care.

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

BPAS continually evaluates our services to ensure they meet women's needs. Following the roll-out of our Pills by Post service, we conducted a review with 1333 clients. The full paper has been submitted to the international journal Contraception and is available here - https://authorea.com/doi/full/10.22541/au.160691768.87050587. Key findings included:

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

Waiting times – positive impact

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

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

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

Impact on abortion providers

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.

The change has had a positive impact.

Abortion providers have variously described the changes in regulation as 'revolutionary' and 'one of the success stories of the pandemic'. The change has enabled services in Wales to provide safe and effective services that are more accessible than ever before.

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

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

According to detailed large-scale analysis, the change in regulation has led to a reduction in gestation at time of treatment, coupled with no changes to complication rates. Analysis indicates that this will, in the medium to long term, reduce the costs of providing an early medical abortion service – enabling Health Boards to focus on using money to improve service provision e.g. for later or more complex care, contraception, or STI testing. In NHS services, these savings are particularly notable as a result of the reduced need for theatre space, day beds, and under pressure speciality professionals such as anaesthetists.

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

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

Mitigation of risks

What risks do you consider are associated with the temporary measure? If you consider that there are risks, can these risks be mitigated?

Medical procedures and risk

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

Abortion providers across Great Britain have worked hard to establish a safe, effective, and accessible telemedical abortion model at a time when all other healthcare has been under substantial pressure. This has resulted in thousands of women in Wales accessing care that otherwise they may have struggled to obtain.

A recent BPAS client satisfaction survey of 1333 clients found that 85% of clients did not contact a healthcare professional during or after their procedure. Of those who did, 78% reported contacting the BPAS 24-hour aftercare line. The principle reasons for contact were to ask questions about administration, to ask about normal levels of pain and/or bleeding, or to discuss aspects of care such as the follow-up pregnancy test. 3.1% of clients contacted a hospital following their procedure – in line with early medical abortion care without a telemedical component.

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

- Royal College of Obstetricians and Gynaecologists
- Royal College of Midwives
- Royal College of Nursing
- Royal College of General Practitioners
- Royal Pharmaceutical Society
- College of Radiographers
- Faculty of Sexual and Reproductive Healthcare
- British Society of Abortion Care Providers
- British Medical Association

Ectopic pregnancies

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

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

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

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

The large cohort study (https://doi.org/10.1111/1471-0528.16668) found that the telemedical model ‘resulted in very low rates of undiagnosed ectopic pregnancy’ (0.03%), with a ‘not significantly different’ number of ectopic pregnancies detected after treatment in the new pathway compared to the previous pathway.

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

Late for LMP presentations

Since the change in clinical practice to rely on Last Menstrual Period (LMP) rather than a scan for determining gestational age, there have been a very small number of cases involving gestations outside the 10-week limit for pills at home. The initial indication was that this risk

would be around 1 in 1000 – 0r 0.1%. The risk now appears to be significantly lower, at 0.04%, as previously noted. This means you would need to compel 10,000 women to undergo a transvaginal or abdominal scan – which women often find invasive and unpleasant – in order to prevent four cases of a woman being treated whose pregnancy was in excess of 10 weeks.

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

The effect on wider healthcare

In your experience, have other NHS Wales services been affected by the temporary approval? If so, which?

Before the approval of mifepristone at home, thousands of women in Wales were passing their pregnancies at home. Even prior to the approval for the home use of misoprostol, women were not remaining in hospital to pass their pregnancy, but instead travelling home often while suffering the early stages of miscarriage. Complications in need of healthcare support are disproportionately likely to happen at this stage rather than in the early

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

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

Safeguarding and domestic abuse

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.

No – in fact, based on evidence from the past year, forcing clinic attendance is likely to result in reduced safeguarding disclosures and increasing numbers of vulnerable women and girls turning to illegal, unregulated sources of abortion medication online.

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

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

issues to us because of their more familiar setting – enabling us to better support them, whatever their need.

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

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

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

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

These findings reflect the conclusion that telemedicine is not a barrier to the discussion of safeguarding or domestic abuse concerns. Where BPAS is treating an adult, there will be a discussion about whether she wants to involve the police or be referred into services such as a refuge. Many women will not want to pursue further support at that moment, although may engage once the termination is complete, and as with all other healthcare providers, we do not require women to engage with other services in order to provide care. However, where we believe there is a risk either to existing children or, if the woman opts to continue her pregnancy after her consultation, to her child when it is born, we are under a legal obligation to involve social services. This is also the case where we are concerned about girls and young women under the age of 18 who present to us.

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

Equality and diversity

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?

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

Telemedicine enables providers to tailor care to individual women and their needs. Some women are disproportionately likely to encounter difficulties in accessing in-person care –

including mothers, victim-survivors of sexual violence, women experiencing domestic abuse, teenage women and girls, women from deprived areas, LGBTI people, disabled women, BAME and migrant women, homeless women, women with mental health or substance use issues, and women with insecure immigration status.

Particularly:

- **Race/ethnicity and religion** – Women from certain religious or cultural backgrounds may experience greater difficulties in accessing in-person care as a result of their living or social arrangements. Travelling a greater distance to a standalone hospital or clinic may be impractical or impossible if they are unable to attend healthcare appointments alone. Further, we have received reports from religious women that their experience of anti-abortion protesters outside clinics has a negative impact on their mental health and in some instance and caused severe anxiety.
- **Age** – younger women and girls may find it more difficult to travel to in-person appointments to lack of access to private transport, the cost of public transport, and education or work commitments.
- **Disability –** Disabled women may have different access needs which affect their capacity to visit hospitals and clinics in *person or* mean that they *must* forgo privacy in order to have support to attend or access premises. This applies to women with physical disabilities who may also struggle to access scans, but also women with disabilities such as agoraphobia which limit their ability to attend healthcare premises.
- **Pregnancy and maternity –** Women who are already mothers account for more than half of all abortions across the UK. Requiring all women to attend clinics for lengthy appointments often means that childcare has to be found, and either privacy compromised, or money found to pay for professionals. This concern is particularly acute where women are caring for a child with special needs where respite care is unavailable.

Socio-economic equality

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?

In the 20th Century, socio-economic status should not impact one's ability to access reproductive healthcare, but sadly it does. There are hidden costs to accessing abortion services, some of which are removed by early medical abortion at home.

Figures from elsewhere in the UK show that those who are most deprived are more than twice as likely to need to access abortion services as women who are least deprived and are disproportionately likely to access services later in pregnancy. BPAS knows that more deprived women are disproportionately likely to ask us to delay care that requires them to travel until they are next paid or receive their benefits – because existing NHS travel costs schemes do not fund self-referred abortion travel.

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

- The high cost of childcare
- Families where women do not have access to an independent income and wish to keep their travel and treatment private

- The disproportionate likelihood of being employed in precarious jobs or with zero-hours contracts, which may make it more difficult to get time off work for appointments and to pass the pregnancy in the days subsequent to the appointment
- Disproportionate reliance on public transport which affects the cost, time, and difficulty of attending an in-person appointment – particularly in more rural and remote areas

The future of home use of mifepristone

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

Yes. BPAS supports the permanent approval of home use of mifepristone.

Welsh language

We would like to know your views on the effects that the Termination of pregnancy arrangements in Wales would have on the Welsh language, specifically on opportunities for people to use Welsh and on treating the Welsh language no less favourably than English. What effects do you think there would be? How could positive effects be increased, or negative effects be mitigated?

Welsh language availability is key to provision within Wales, both in the NHS and in commissioned services such as BPAS. We do not believe there is any impact on the Welsh language of telemedical abortion care.

As a service, BPAS provides abortion information and clinical care in Welsh where requested. However, not all of our staff members speak Welsh. The provision of telemedical care enables us and other providers to book appointments specifically with Welsh-speaking staff if requested by clients, whereas in-person care relies on staff availability and potentially increased waits for Welsh-speaking staff to become available.

Telemedical abortion care is provided by the same staff as in-person care throughout Wales, so in and of itself, there will be no impact of this change on the availability of care in Welsh.

Please also explain how you believe the proposed arrangements could be formulated or changed so as to have positive effects or increased positive effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language, and no adverse effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language.

Abortion care is an NHS service, and as such should be treated no differently to other healthcare when considering the effects of the Welsh language.

Any other thoughts

We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:

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

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

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

The ability to provide the best possible abortion care in Wales should be governed by clinical frameworks and guidelines, and not by the criminal law. In Scotland, the Scottish Abortion Care Providers network determined that 12 weeks' gestation was the more appropriate limit for home

use of mifepristone and misoprostol – a finding supported by international evidence. Their framing also better allows effective cross-border care, and care grounded in the qualifications of clinicians providing care (doctors, nurses, and midwives in the case of Wales) rather than it being tied to other licensed premises.

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

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

www.bpas.org
February 2021

From:	Griffiths, John (Aelod o'r Senedd | Member of the Senedd)
To:	Women's Health – Iechyd Menywod
Subject:	Consultation on Termination of Pregnancy Arrangements in Wales
Date:	20 February 2021 00:29:15

I write in support of retaining the changes introduced during the pandemic to permit early medical abortion without the need to attend a clinic. I believe the current temporary regulations should be made permanent to allow telemedical early medical abortions. So that pills may be taken at home following a telephone consultation with a clinician.
I do think this will lead to earlier and safer abortions.
Yours sincerely
John Griffiths

Sent from my iPhone

Royal College of Obstetricians & Gynaecologists

Consultation on the future arrangements for early medical abortion at home

RESPONSE TO THE WELSH GOVERNMENT

FEBRUARY 2021

Background and introduction

1. The Royal College of Obstetricians and Gynaecologists (RCOG) works to improve the health and wellbeing of women everywhere, by setting standards for clinical practice, providing doctors with training and lifelong learning, and advocating for women's health globally. Founded in 1929, the RCOG now has over 16,000 members worldwide and works with a range of partners both in the UK and globally to improve the standard of care delivered to women, encourage the study of obstetrics and gynaecology and advance the science and practice of the specialties.

2. The RCOG produces abortion care guidance for its members, and recently co-produced the National Institute of Health and Care Excellence (NICE) 'Best Practice Abortion Care Guidance [NG140]'[1]. The RCOG has also published the 2011 Green-top Guideline 'The Care of Women Requesting Induced Abortion'[2], in addition to other best practice papers, reports and guidance relating to abortion care.

3. In response to the coronavirus (COVID-19) pandemic, the Welsh Government approved the home use of both pills required to affect an early medical abortion (EMA) on 31 March 2020[3]. This was in recognition of a deepening public health crisis which negatively impacted on the ability of people requiring an abortion to travel, and the potential that such travel could contribute to the transmission of COVID-19 to women, their families and healthcare professionals.

4. The law relating to abortion in Wales is governed by the Abortion Act 1967 (the Act)[4], with ministers in Wales able to exercise the powers conferred by the Act. This includes the power to approve a class of 'place'. In 2018, this power was used to allow women to take misoprostol, the second medical abortion pill, at home.

5. At the beginning of the pandemic, the RCOG supported the introduction of the home use of both abortion pills (mifepristone and misoprostol) and urged all UK governments to make the

[1] NICE. Abortion care guideline [NG140], London: National Institute for Health and Care Excellence; 2019 [Available from: https://www.nice.org.uk/guidance/ng140/]
[2] RCOG. The Care of Women Requesting an Induced Abortion, London: Royal College of Obstetricians and Gynaecologists, 2011 [Available from: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/the-care-of-women-requesting-induced-abortion/]
[3] Welsh Government. The Abortion Act 1967 – Approval of a Class of Place for Treatment for the Termination of Pregnancy (Wales) 2020 [Available here: https://gov.wales/sites/default/files/publications/2020-04/approval-of-a-class-of-place-for-treatment-for-the-termination-of-pregnancy-wales-2020.pdf]
[4] UK Government. Abortion Act 1967. Available here: https://www.legislation.gov.uk/ukpga/1967/87]

necessary regulatory changes to ensure this provision was possible by law.

6. In collaboration with the Royal College of Midwives, the Faculty of Sexual and Reproductive Healthcare and the British Society of Abortion Care Providers, the RCOG published professional guidance specific to abortion care services during the pandemic on 21st March 2020 entitled 'Coronavirus (COVID-19) infection and abortion care'[5]. Its first iteration was published prior to the regulatory change in Wales permitting the home use of mifepristone but advocated for a more remote pathway for early medical abortion. It also stated:

> *"It should be a priority for each of the four nations to consider any emergency legislative or regulatory changes which would enable greater use of telemedicine to deliver abortion care, and ease restrictions on which healthcare professionals are permitted to certify an abortion. Where possible, the four nations should align their approaches to ensure consistency and minimise confusion."*

7. Following the approval of the home use of mifepristone, the RCOG published updated guidance which included a new telemedicine pathway for early medical abortion care, ensuring consistency, quality, and safety. The guidance has been updated throughout the pandemic and includes information for girls and women reviewed by the RCOG's lay representative network[6]. Protocols have been rapidly developed to support the delivery of this new pathway[7].

8. The current pathway for early medical abortion care is clearly presented in a process chart within the RCOG's guidance "Coronavirus (COVID-19) infection and abortion care" and presented below in Figure 1. This process chart is supplemented by a decision aide, available alongside the guidance, to ensure that eligibility for telemedicine EMA is understood [8].

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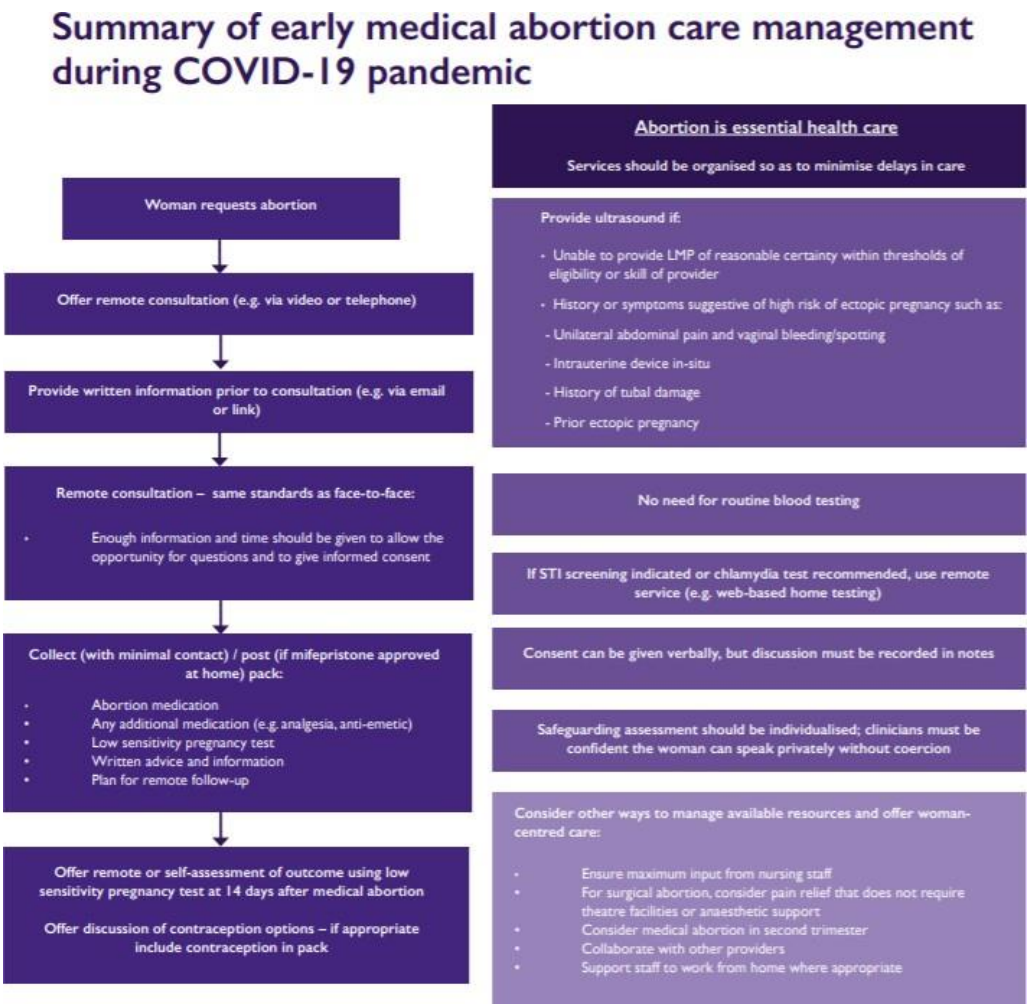
[5] RCOG. Coronavirus (COVID-19) infection and abortion care, London, Royal College of Obstetricians and Gynaecologists, 2020. [Available here: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/coronavirus-abortion/]

[6] Coronavirus (COVID-19) infection – Information for women requiring abortion, Royal College of Obstetricians and Gynaecologists. [Available here: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/coronavirus-abortion/information-for-women/]

[7] Raymond EG, Grossman D, Mark A, et al. No-test medication abortion: a sample protocol for increasing access during a pandemic and beyond. *Contraception* 2020;101:361-66.

[8] RCOG Decision aide for early medical abortion without ultrasound, London 2020. [Available here: https://www.rcog.org.uk/globalassets/documents/guidelines/2020-06-04-decision-aid-for-early-medical-abortion-without-ultrasound.pdf]



9. For those eligible for the telemedicine pathway following consultation with a healthcare professional, women are provided with a treatment package which includes abortion medication, analgesia, anti-emetic, a pregnancy test, advice and information and a plan for follow-up care. The RCOG recommends that post-abortion support and advice is available 24/7.

10. Those eligible no longer require a routine transvaginal ultrasound scan to determine the duration of the pregnancy. Instead, women are asked a series of questions to identify their last menstrual period (LMP). A prospective trial of 4,484 women seeking early medical abortion found that 1.2% of women whose LMP dated them to less than 10 weeks had ultrasound dating of over 10 weeks, demonstrating a high degree of accuracy[9].

[9] Bracken, H et al. Alternatives to routine ultrasound for eligibility assessment prior to early termination of pregnancy with mifepristone-misoprostol. BJOG. 2011;118:17-23.PM:21091926 [Available here: https://pubmed.ncbi.nlm.nih.gov/21091926/]

11. A recent national cohort study of 29,984 telemedicine early medial abortions in England, Wales and Scotland demonstrated a high degree of accuracy when estimating LMP. Of this number, 0.04% were over 10 weeks' at the time of the abortion, and all completed safely at home[10].

12. Since the introduction of the temporary approval for mifepristone at home, the RCOG has monitored the quality, safety, efficacy, and efficiency of telemedicine abortion care. This has included ongoing discussions with abortion care providers, Governments, regulators and has involved routinely collecting relevant data and undertaking a health economic analysis.

13. We welcome the decision by the Welsh Government to consult on making this temporary approval permanent.

14. It is important to note that the powers available to Ministers with respect to the Abortion Act 1967 are restricted to deciding whether a woman's home is an approved class of place for an early medical abortion. The Act provides a legal framework, it does not provide a clinical framework, which instead is informed by best practice and guidance issued by organisations such as the RCOG. The use of ultrasound scanning to determine gestation is therefore a clinical, and not a legal decision, and not part of the legal framework. In some states in the USA, politicians have attempted to restrict abortion care by introducing laws that require intravaginal scanning of all women (for instance, the State of Alabama, H.R.490 Heartbeat Protection Act of 2019[11]).

15. Within this document we use the terms girls, women, and women's health, however it is important to acknowledge that it is not only people who identify as women for whom it is necessary to access women's health and reproductive services to maintain their gynecological and reproductive wellbeing. Gynecological and obstetric services and the delivery of care should be inclusive and respectful to the needs of those people whose gender identity does not align with the sex they were assigned at birth.

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[10] Aiken, A., Lohr, P.A., Lord, J., Ghosh, N. and Starling, J. (2021), Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study. BJOG: Int J Obstet Gy. [Available here: https://doi.org/10.1111/1471-0528.16668]

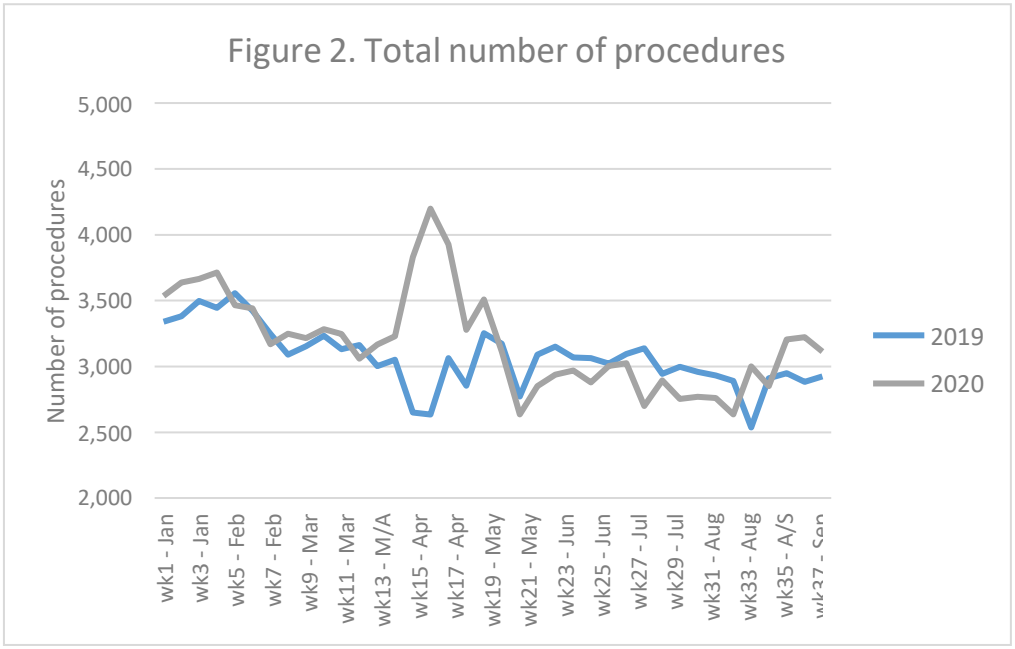
[11] State of Alabama, H.R. 940 Heartbeat Protection Act of 2019. Alabama, 2019. [Available here: https://www.congress.gov/bill/116th-congress/house-bill/490?r=1&s=1]

Question 1: 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.

16. The temporary approval has had a positive impact on safety, accessibility and convenience.

17. The safety of abortion care has improved due to the home use of mifepristone. Abortion care is a safe procedure and made safer the earlier on in the pregnancy that is it undertaken[12]. Mortality and morbidity with abortion is very low, and significantly lower than continuing a pregnancy to term, but increases with the duration of the pregnancy[13].

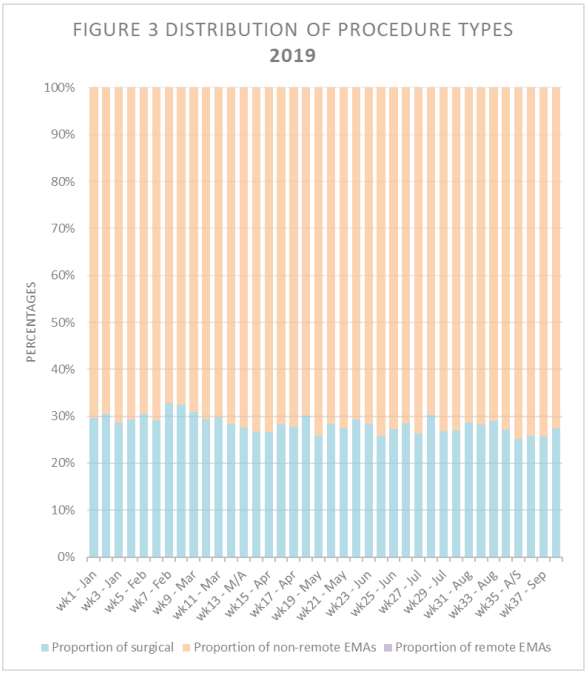
18. Since the introduction of this new pathway, the RCOG has collected data from the three main independent sector abortion care providers in England and Wales. These are the British Pregnancy Advisory Service (bpas), the National Unplanned Pregnancy Advisory Service (NUPAS) and MSI Reproductive Choices UK (MSIUK), who together provide the majority of early medical abortions in England and Wales. The data is limited because it does not take into consideration data from NHS Trusts and Health Boards. However, further investigation concerning telemedicine within NHS organisations is also considered later.

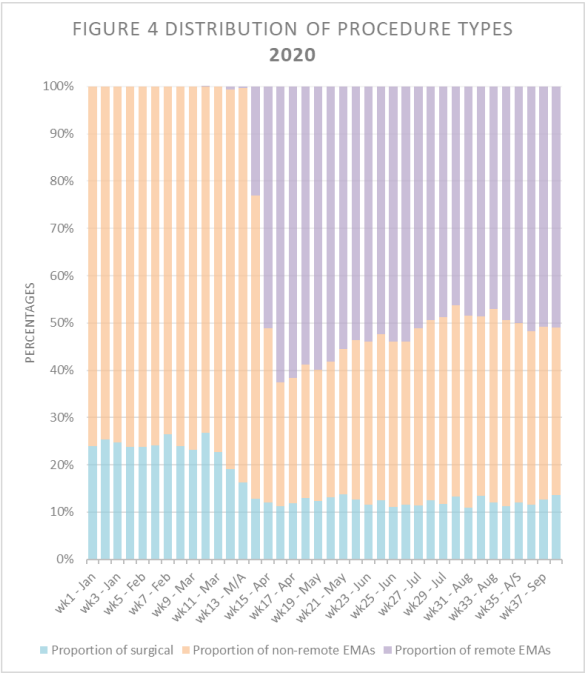


[12] NICE, Abortion care guideline [NG140]
[13] Ibid.

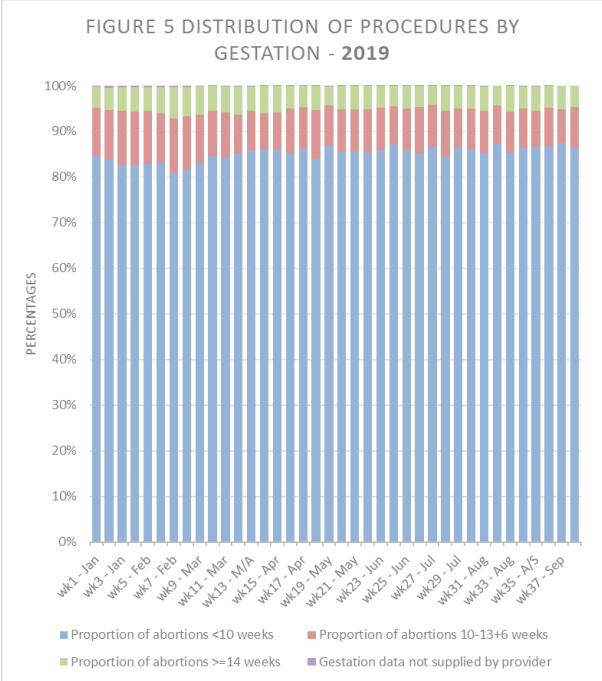
19. Figure 2 compares the total number of abortion procedures undertaken in England and Wales between Jan-Sept by independent sector providers in 2019 (n=116,663) and 2020 (n=121,093). This number shows a slight increase in the number of procedures undertaken by these providers.

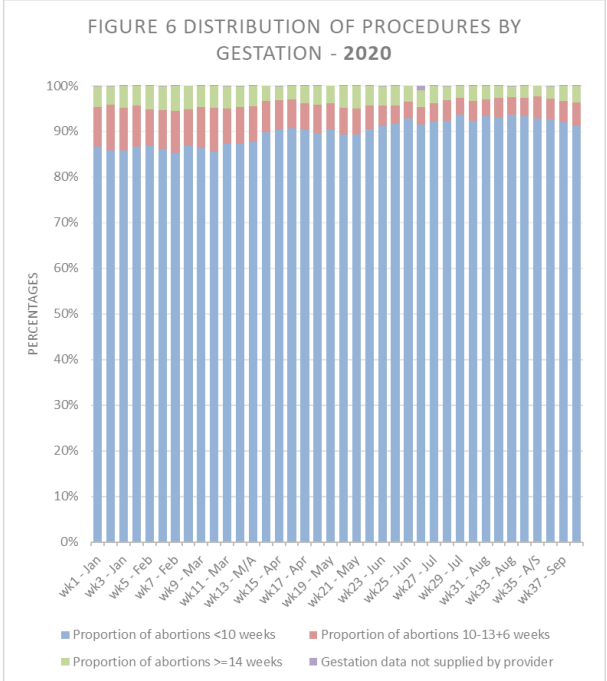
20. Figure 3 represents the distribution of procedures in England and Wales during 2019 in the independent sector and Figure 4 represents the same distribution in 2020. Despite the total number of procedures increasing during this period, the number of surgical procedures, usually undertaken after the duration of the pregnancy has passed 10 weeks, has reduced substantially.



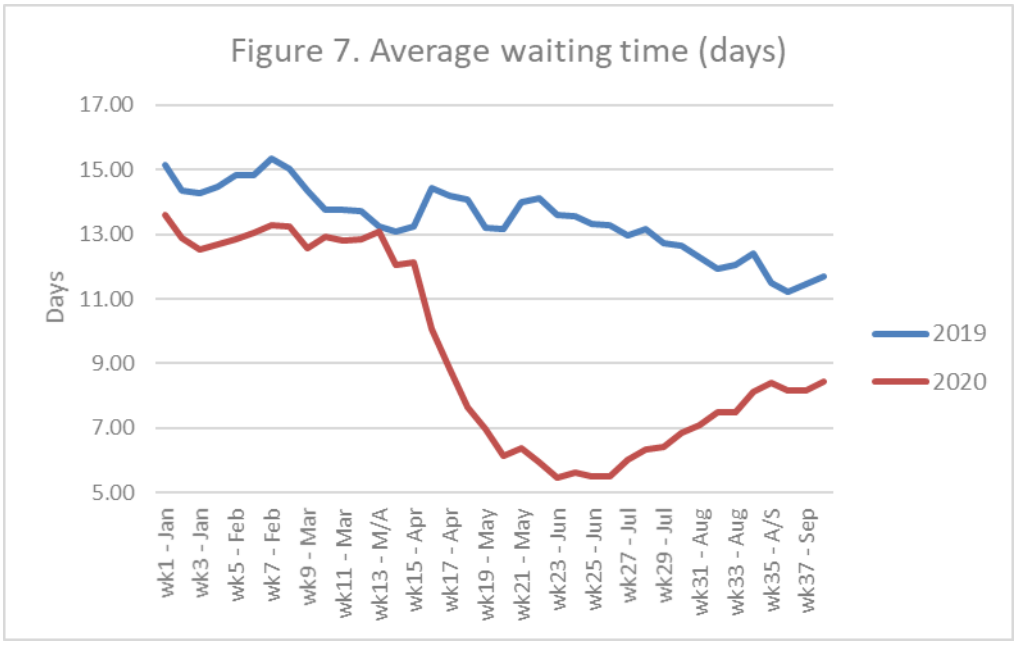


As shown in Figure 5 and Figure 6 below, this corresponds to the increase in the proportion of procedures undertaken before the 10th week of pregnancy in the independent sector.



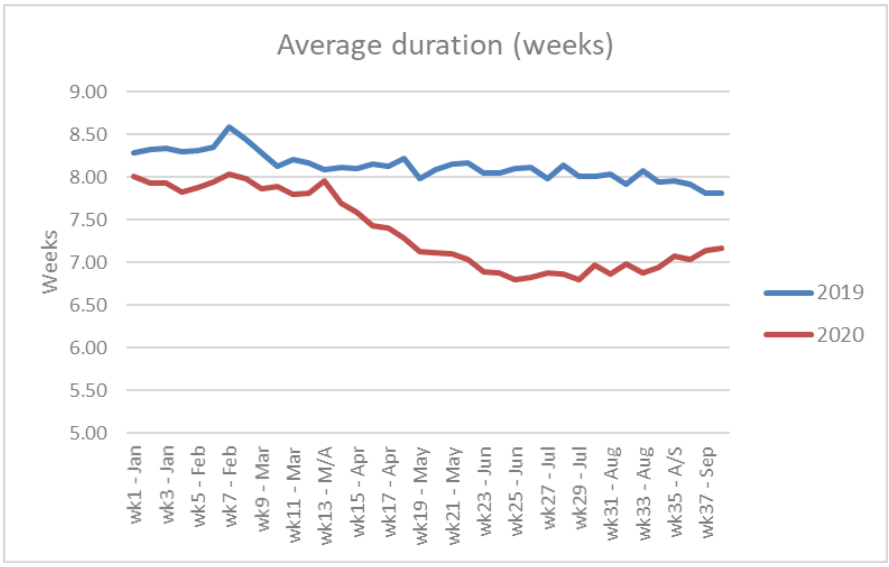


15. As stated earlier, abortion care is considered a safe procedure, but the risk of adverse events is lower earlier in the pregnancy. Therefore, an increase in the proportion of the number of abortions performed before 10 weeks is significant. As the consultation paper rightly states, this is likely due to shorter waiting times which has decreased the average duration of pregnancy for women seeking an abortion. This is evident in Figure 7 below, which again is an aggregated average waiting time to procedure between the three main independent sector providers in England and Wales and shows the longest waiting time in 2019 of 15.34 days, and the lowest waiting time in 2020 of 5.48 days.



This substantial decrease in waiting times has been sustained with a slight increase in waiting times during a period of fewer national restrictions. During this period the number of women choosing to attend a clinic also increased, which may indicate that some women will prefer an in-clinic appointment, and that this choice should be available.

16. Figure 8 below shows the corresponding fall in the average duration of pregnancy within the independent sector.



This is from a high of 8.58 weeks in 2019 to a low of 6.79 weeks in 2020. The reduction in the average duration of pregnancy has been sustained and is now well within the best practice recommendations set by NICE, which recommends that assessment should be within 1 week of request, and the procedure should take place within 1 week of the assessment[14].

17. In addition to the data collected from independent sector providers, the provisional data published by the UK Department of Health and Social Care covering the period January 2020-June 2020 shows that in England and Wales, 86% of all abortions were performed at under 10 weeks, compared to 81% during the same period in 2019. Almost 50% of abortions were performed before 7 weeks, compared to 40% during the same period in 2019[15].

18. All the data therefore shows markedly reduced waiting times and reduced duration of pregnancy. This is both kinder for women, who can be seen quicker to resolve an unwanted pregnancy, and

[14] Ibid.
[15] DHSC. Abortion statistics during the coronavirus pandemic: January to June 2020 London: Department of Health & Social Care; 2020 [Available from: https://www.gov.uk/government/statistics/abortion-statistics-during-the-coronavirus-pandemic-january-to-june-2020]

safer, given the increase in complications as the duration of a pregnancy increases.

19. A national cohort study has recently been published based with data from independent sector providers in England and Wales. This compares the effectiveness, safety, and acceptability of medical abortion before and after the introduction of the telemedicine abortion pathway (named in the paper as the "no-test telemedicine-hybrid care model") to the traditional service model (which includes the blanket in-person provision including transvaginal ultrasound scanning). The study of 52,142 medical abortions compares these two cohorts: 22,158 in the traditional cohort in the 2 months prior to telemedicine, and 29,984 in the two months following the introduction of telemedicine. The study shows that there was no difference in the prevalence of serious adverse events (0.04% vs. 0.02%) and the effectiveness for abortions in the telemedicine cohort (99.2%) was higher than for those conducted in person (98.1%). The incidence of ectopic pregnancy was equivalent.[16]

20. The national cohort study concludes that medical abortion provided through a hybrid model that includes no-test telemedicine without routine transvaginal ultrasound is effective, safe, acceptable, and improves access to care.

21. A further cohort study of 663 women at the NHS Lothian telemedicine service between April 1st and 9th July 2020 also demonstrates the safety of this service, with similarly low rates of adverse events, and concluding that the model is "safe, has high efficacy and high acceptability amongst women."[17]

22. This conclusion is supported by the data reported to the Welsh Government by Health Boards, showing low rates of adverse events.[18]

[16] Aiken, A., Lohr, P.A., Lord, J., Ghosh, N. and Starling, J. (2021), Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study. BJOG: Int J Obstet Gy. [Available here: https://doi.org/10.1111/1471-0528.16668]

[17] Telemedicine medical abortion at home up to 12 weeks' gestation – a prospective observational cohort study during COVID-19.

[18] Welsh Government. Consultation on Termination of Pregnancy Arrangements in Wales. [Available here: https://gov.wales/sites/default/files/consultations/2020-12/termination-of-pregnancy-arrangements-in-Wales_1.pdf]

23. Mifepristone itself is regarded as a very safe drug. Not only is it taken by large numbers around the world, but comparatively speaking, it is safer than other drugs that are much easier to access[19].

24. The temporary approval has expanded access and made care more personalised, less medicalised, and kinder for women. The legal restrictions on 'place' associated with the previous model of care, which mandated that mifepristone had to be taken in a clinic or hospital, presented barriers to women, both in terms of whether they could access care, and how convenient that care was.

25. The use of telemedicine has been a response to the COVID-19 pandemic, but many organisations have recommended greater use of telemedicine in abortion care, including NICE[20]. This is mainly due to the significant changes in the delivery of abortion care over the last two decades. With most abortions now undertaken before 10 weeks, and by a medical regimen of pills, the Abortion Act 1967 is increasingly anachronistic and has not kept pace with medical practice or innovation.

26. In person attendance at a clinic or hospital requires the means to travel, possibly to arrange childcare and may involve absence from work. Removing these barriers is likely to continue to be favoured by women. Qualitative studies show that reasons for travel to access abortion care do not mention a preference to see a healthcare professional face-to-face, but rather due to the lack of a local, in-clinic service, or because of legal restrictions (for example, in some states in the USA).[21] Suggesting that a telemedicine model is preferred.

27. The new pathway also provides women with greater choice around when to commence their early medical abortion. Taking the first abortion pills begins the abortion process, and therefore that process is determined by appointment availability. By permitting the home use of abortion pills, women may now decide, for instance, to begin the process over the weekend, or at a more convenient time.

28. We also consider the more nuanced approach to early medical abortion care, where care is available in a woman's home if eligible, is better than the previous model of care which routinely

[19] MHRA yellow care scheme [Available here: https://info.mhra.gov.uk/drug-analysis-profiles/dap.html?drug=./UK_EXTERNAL/NONCOMBINED/UK_NON_000602185680.zip&agency=MHRA]
[20] NICE, Abortion care guideline [NG140]
[21] Barr-Walker J et al. Experiences of women who travel for abortion: A mixed methods systematic review. 2019. [Available here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6456165/]

determined the duration of the pregnancy by ultrasound scan. Early in the pregnancy this is assessment is undertaken by a transvaginal ultrasound scan, which involves a small probe passing into the vagina. Understandably, intimate examinations should be kept to a minimum, and given the high degree of accuracy in estimating the duration of the pregnancy via LMP, it is highly unlikely that abortion providers will revert to providing ultrasound scans for all women. As stated in the introduction, under the provisions of the Abortion Act 1967, ministers only have the power to determine where an abortion can take place, not to require ultrasound scanning for all women. Given that providers are unlikely to return to scanning all women, demanding that women attend a clinic simply to take a pill would be unreasonable, act as a barrier to access and inconvenience women.

29. There will be some women who may be more specifically disadvantaged by a return to the previous model of care. We would expect that the Welsh Government would undertake an equality impact assessment to understand this impact in-depth. This may include:

    - **Socio-economic disadvantage**. Where the cost of travel or other enabling costs (such as childcare) is prohibitive.
    - **Rurality**. Where the distance to access in-person care prevents or inhibits access.
    - **Low paid workers.** Especially those who rely on statutory sick pay for work absences.
    - **Victims of domestic abuse.** Who otherwise could not attend an in-clinic appointment, and therefore would not have access to safeguarding via telemedicine.

    In a later question we will also consider the potential implications for individuals with a protected characteristic.

30. Since the beginning of the pandemic, studies have also shown those nations who adopted the use of telemedicine (Scotland, England, Wales, France, South Africa) have reduced the dependence on unregulated methods of abortion. One study considers the impact of national lockdowns due to the COVID-19 pandemic on demand for abortion pills online. Unsurprisingly, those countries where abortion care is only provided in hospitals, or not provided at all, experienced a significant increase in demand for unregulated pills. In Northern Ireland, where abortion is now legal but inaccessible for many women, and with travel to Great Britain disrupted, there was an increase in demand of 28%. In Portugal where abortion care is only provided in hospitals with a 3-day waiting period, requests were 139% above expected demand. In Great Britain, however, where each

government permitted the home use of abortion pills, demand fell by 88%. [22]

31. In addition to better access and convenience, reducing reliance on unregulated forms of abortion is safer. Abortion remains a criminal offence in England and Wales, unless provided under the terms of the 1967 Act. Permitting women to access abortions in their own homes, without the need for an in-clinic visit, reduces the potential criminalisation of women who may otherwise seek an abortion outside of the formal healthcare system.

32. MSI Reproductive Choices UK has considered patient acceptability and surveyed 1,243 women who had an abortion through their telemedicine pathway[23]. The results show:

    - 95.3% patients felt able to talk privately
    - 99.3% had the opportunity to ask any questions
    - 92.4% reported they had enough information to manage the process at home
    - 87.4% had no concerns about taking the medication by themselves (concerns highlighted were general concerns about the effectiveness of the regimen)
    - 98.2% rated their experience as good/very good.
    - 83.3% said they would not have preferred a face-to-face pathway.[24]

33. The British Pregnancy Advisory Service has also surveyed 1,144 women who had used their telemedicine pathway. The results show similarly high satisfaction levels, with 97% reporting they were satisfied or very satisfied with the service. 77.8% would prefer the telemedicine service in the future, and that they valued this service because it provides greater flexibility over the timing of the administration. [25]

34. Acceptability was also discerned from NHS Lothian, 574 (86.6%) women rated the service as 'somewhat' (n=24, 3.6%) or 'very' (n=550, 83%) acceptable.[26]

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[22] Aiken, A R A. et al., Demand for Self-Managed Online Telemedicine Abortion in Eight European Countries During the COVID-19 Pandemic: A Regression Discontinuity Analysis (2020) [Available here: https://srh.bmj.com/content/early/2021/01/11/bmjsrh-2020-200880.info]

[23] Erlank CP, Lord J, Church K. Early medical abortion using telemedicine - acceptability to patients. Pre-print [Available here: https://wwwmedrxivorg/content/101101/2020111120229377v1]

[24] https://www.medrxiv.org/content/10.1101/2020.11.11.20229377v2.full-text

[25] Meurice M, Whitehouse K, Blaylock R, et al. Client satisfaction and experience of home use of mifepristone and misoprostol for medical abortion up to 10 weeks' gestation at British Pregnancy Advisory Service: a cross-sectional evaluation. *Pre-print* [Available here: *https://authoreacom/doi/full/1022541/au16069176887050587*]

[26] Telemedicine medical abortion at home up to 12 weeks' gestation – a prospective observational cohort study during COVID-19

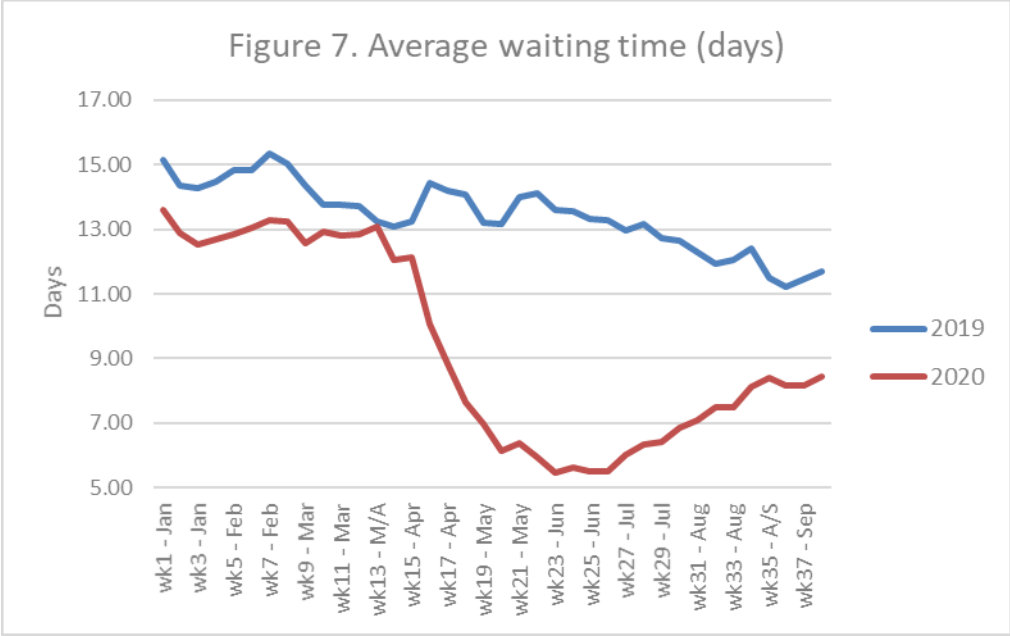
35. Waiting times have significantly decreased since the introduction of the telemedicine care pathway. This is important for two reasons; risks are lower when the abortion is carried out sooner, and often women wish to be seen quickly so that the experience is dealt with as soon as possible. Delays and long waiting times can negatively impact women, either by restricting their choice around the abortion (for instance, in England and Wales, the telemedicine pathway is only available until 10 weeks) or by leaving them with an unresolved pregnancy for longer than necessary.

36. The NICE /RCOG best practice guidance recommends that all barriers should be removed to ensure time to appointment and time to procedure are as short as possible[27]. The guidance states that women should have an appointment within one week of their request. Since the introduction of telemedicine across Great Britain, average waiting time to procedure has reduced significantly and now generally meets best practice. This is evident in data collected by the RCOG and as part of the national cohort study.

37. The national cohort study showed that the mean waiting times were 4.2 days shorter for women accessing abortion care through the telemedicine pathway[28]. Figure 7 below shows the RCOG data, a precipitous decline in waiting times and sustained, shorter waiting times in comparison to the same period in the previous year.

[27] NICE, Abortion care guideline [NG140]

[28] Aiken, A., Lohr, P.A., Lord, J., Ghosh, N. and Starling, J. (2021), Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study. BJOG: Int J Obstet Gy. [Available here: https://doi.org/10.1111/1471-0528.16668]



38. With fewer women requiring follow-up care or a surgical abortion, there is an economic saving to the health system. Provisional modelling from an economic analysis of the NHS Lothian data shows savings of around £272.07 per medical abortion at home, against a cost of medical or surgical abortion in hospital. For the cohort analysed as part of the Lothian study (n=663) and considering costs associated with reported adverse events, this equates to total savings of around £205,681 for the service during that period.

Question 2: 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.

39. The temporary measure has had a positive impact.

40. At the beginning of the pandemic, it was necessary to protect staff and women from potential transmission and infection of COVID-19. It was also vital to protect abortion services that suffered staff sickness, self-isolation, and clinic closures.

41. Providers have reported that the number of women self-referring to abortion services has increased. Self-referral was a key recommendation in the NICE /RCOG best practice abortion care guidance issued in 2019, and reduced demand on other areas of the health system (e.g., general

practice).[29]

42. Providers also report that clinics are more efficient, and crucially the pathway is more personalised for women. Reducing clinically unnecessary appointments allows greater focus on those women with more complex needs.

43. The temporary approval permitted doctors to prescribe from home, in order to ensure services could continue to operate should staff sickness or self-isolation become an issue. While this has been especially relevant during the coronavirus pandemic, continuing to allow this flexibility is helpful for recruitment and retention, and permits flexible working and better work-life balance.

44. The pathway also allows more time for women to consider their options between and after appointments. With more information provided in written and audio-visual formats at the initial presentation, women can take more time to reflect on the information and ask any pertinent questions as part of the telemedicine consultation. Previously, this would all have been done face-to-face, which understandably can be stressful.

45. A further benefit is a more efficient certification process. One of the demands of the previous pathway, where mifepristone had to be taken in clinic, was the need to find a second registered medical practitioner to certify the abortion. Rather than keeping women waiting while a second doctor is found, this process can now be done without delay. This is often not a problem for independent sector providers, but doctors working in the NHS have a variable caseload and often see a mix of patients with different needs.

46. A health economic analysis, undertaken by the RCOG, demonstrates a number of cost efficiencies with this new pathway. The evaluation adapted the economic model produced for the NICE Guideline on Abortion Care[30]. All parameters from the NICE model were updated to the more recent or applicable evidence and to enable the comparison of the telemedicine model of care compared to the former pathway for early medical abortion. By reducing the waiting time between initial presentation and the abortion procedure, and thereby reducing the gestation at which abortion is done, savings could be made by allowing women to choose between the simpler medical rather than surgical procedure and between expulsion at home or in a more

[29] NICE, Abortion care guideline [NG140]
[30] NICE, Abortion care guideline [NG140]

costly clinical setting.

47. For the independent sector in England and Wales, the modelling shows estimated cost savings are £15.80 per abortion representing a saving to the NHS of over £3 million per year. The abortion procedure cost saving represents almost two thirds of the overall cost saving. Over a third of the total cost savings came from a reduction in incomplete abortions.

48. For NHS Trusts, the modelling shows that telemedicine is a cost-effective model of care which can be adapted straightforwardly for Trusts which may not currently provide this service. As with the Lothian data, cost savings to the NHS are likely to be higher given the overheads involved in providing hospital-based care.

Question 3: What risks do you consider are associated with the temporary measure? If you consider that there are risks, can these risks be mitigated?

49. Changes to the early medical abortion pathway at the beginning of the COVID-19 pandemic were substantial, but a natural progression given the advancements made in abortion care in the last few decades. The change to this pathway also fits with the evolving relationship between healthcare professional and patient. Significant legal cases are redefining these interactions and expectations, such as *Montgomery v Lanarkshire Health Board,* where the judgement stated:

> *"The practice of medicine has moved significantly away from the idea of the paternalistic doctor who tells their patient what to do, even if this was thought to be in the patient's best interests. A patient is autonomous and should be supported to make decisions about their own health and to take ownership of the fact that sometimes success is uncertain and complications can occur despite the best treatment."*[31]

Patient autonomy and the ability to make decisions which consider personal circumstances are important in healthcare. Abortion has long been a form of healthcare which is safe, but the restrictions and barriers borne out of the legal framework surrounding abortion, and attitudes in society, have limited the degree to which care can be centred around patient experience, negatively affecting how women can exercise their autonomy. Criticism of this new pathway often ranges from whether women can accurately estimate their last menstrual period, to, in some cases, asserting that women can not be trusted to honestly interact with this service. Both views

[31] Montgomery (Appellant) *v* Lanarkshire Health Board (Respondent) (Scotland) 2015 [Available here: Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (supremecourt.uk)]

are a vestige of a paternalistic approach to healthcare framed in the language of 'risk', and the double standard is evident when compared to how other healthcare is organised.

50. The RCOG has published patient information regarding how risk is discussed in healthcare. This states that:

> *"Risk is the chance that any activity or action could happen and harm you. Almost everything we do has an associated risk. Living is a risky business. People will generally take risks if they feel that there is an advantage or benefit. We need to look at risks and benefits together. Normally the benefits of an action should outweigh the risks. There is no such thing as a zero risk. How you view risk depends to a large extent on your own circumstances and 'comfort zone'."*[32]

It is therefore important that risk is appropriately mitigated, but that women are aware of risk and able to discuss their options openly. Healthcare is always a balance of risk and benefit, and access to the right information is central to informed decision-making.

51. Evidence suggests that women can estimate their last menstrual period (LMP) with a high degree of accuracy. A recent national cohort study showed that of 29,984 women treated via telemedicine, there were 11 cases (0.04%) where the gestational age after abortion was reported as being greater than the expected 10 weeks[33]. In all these cases, the medical abortion was completed at home without additional medical complications. The risk is approximately 1:3000, which is considered 'rare'. Given there were no further complications reported in this cohort, and that medical abortion is safe and effective beyond 10 weeks[34], the event itself is low risk for women. While it is important to communicate to women this risk, given the low event rate, it would not be proportionate to consider this risk significant at a population level. Informed decision making is the appropriate risk mitigation, while further data from providers will support iterating algorithms to further reduce this risk.

52. It has been argued by some groups that this risk profile justifies all women requiring a transvaginal scan to determine the duration of the pregnancy. However, this would result in a significant amount of clinically unnecessary intimate procedures which would be a wholly

[32] RCOG. Information for you: Understanding how risk is discussed in healthcare. London 2015. Royal College of Obstetricians and Gynaecologists. [Available here: https://www.rcog.org.uk/en/patients/patient-leaflets/understanding-how-risk-is-discussed-in-healthcare/]

[33] Aiken, A., Lohr, P.A., Lord, J., Ghosh, N. and Starling, J. (2021), Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study. BJOG: Int J Obstet Gy. [Available here: https://doi.org/10.1111/1471-0528.16668]

[34] Harris LH, Grossman D. Complications of Unsafe and Self-Managed Abortion. N Engl J Med 2020;382(11):1029–40. doi: 10.1056/NEJMra1908412 [doi]

disproportionate response. Legally requiring an ultrasound scan is also beyond the scope of the provisions of the Abortion Act 1967 and would require further legislation.

53. The absolute incidence of ectopic pregnancy in those undergoing abortion is ten times lower than that in the general population, and the national cohort study has reported outcomes on this potential risk. The algorithm which determines eligibility for an early medical abortion at home includes an individualised risk assessment of ectopic pregnancy, including a discussion of symptoms. The data from the study shows an equivalent rate of missed ectopic pregnancies between the traditional pathway (0.2%) (including an ultrasound scan) and the telemedicine pathway (0.2%)[35].

54. It is important that ectopic pregnancies are detected as early as possible and, as with both abortion pathways (traditional and telemedical), there will be women who are asymptomatic and will proceed to have an early medical abortion. The authors of the national cohort study make clear that the most important consideration is that the ectopic pregnancy is identified before harm is caused. Early medical abortion itself does not lead to further complications for women with ectopic pregnancies[36]. If women do have an ectopic pregnancy and proceed with an early medical abortion, those women will have information from providers about what will happen should the pregnancy be ectopic (for instance, very little bleeding), and advice about the next steps. In addition, women will have a 24/7 aftercare line for support if they have any further questions or need advice.

55. Some groups have claimed that following the correct regimen for administering the abortion pills is difficult, leading to complications and unsafe abortion. We have seen no evidence to support that claim, and all providers of telemedicine abortion include step-by-step instructions to follow[37]. The national cohort study, as we have seen, reports complication rates which are equivalent to the traditional model, but with higher efficacy[38]. In addition, providers operate 24/7 helplines for

[35] Aiken A, Lohr P, Lord J, Ghosh N, Starling J. Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study. *Pre-print.*
[36] Shannon C et al. Ectopic pregnancy and medical abortion. [Available here https://pubmed.ncbi.nlm.nih.gov/15229016/]
[37] BPAS. Pills by Post – Abortion Pill treatment at home. [Available here: https://www.bpas.org/abortion-care/abortion-treatments/the-abortion-pill/remote-treatment/]
[38] Aiken A, Lohr P, Lord J, Ghosh N, Starling J. Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study. *Pre-print.*

post abortion care, or any other support women may require with the process.

Question 4: In your experience, have other NHS Wales services been affected by the temporary approval? If so, which?

56. Data referred to shows reduced complications, greater efficacy, and efficiency savings. These are likely to have had a positive effect on other health services.

57. Data we collected from the Aneurin Bevan University Health Board shows that they provided 309 abortions in the period of telemedicine EMA (April-June 2020), compared to 327 abortions undertaken in the period before the change in the law (Jan-March 2020). Between these two time periods, there was a sizeable shift towards both telemedicine and to abortions undertaken at earlier gestation. Before the approval of telemedicine 69% of abortions were undertaken by EMA, compared to 91% after the introduction of telemedicine. The most sizeable change was in the number of surgical abortions done up to 14 weeks gestation which declined from 91 procedures to 21. The shift in gestation and method resulted in an estimated average saving of £188.84 per abortion.

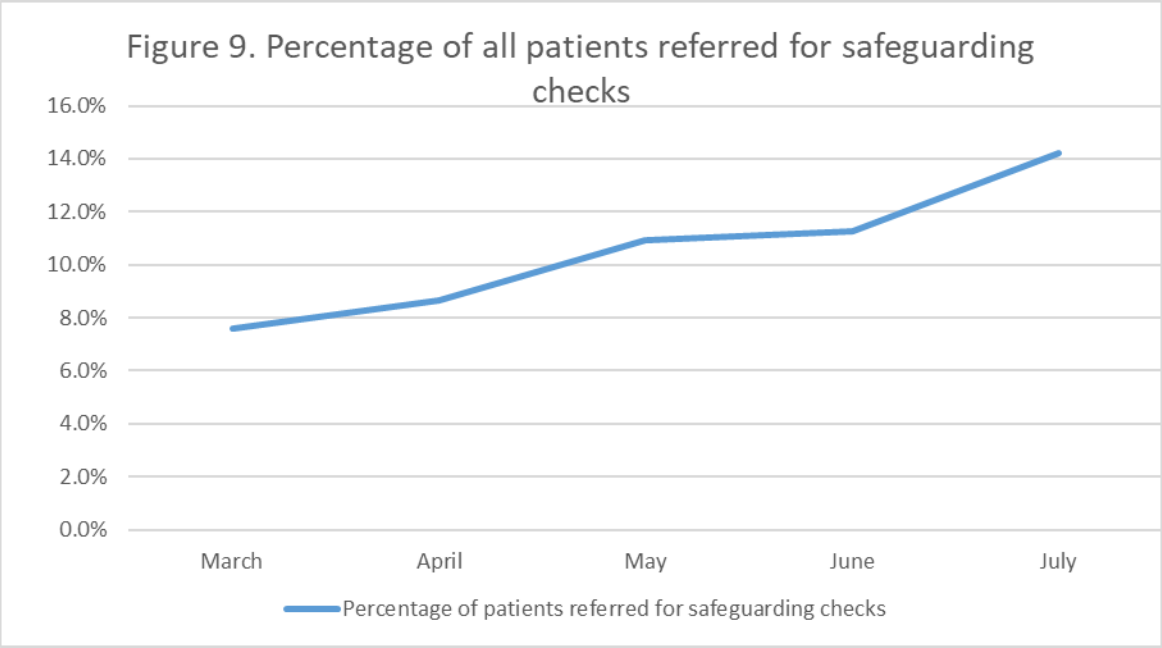
58. Given that women were already taking misoprostol at home prior to March 31st 2020, we do not expect any significant impact on other services by comparison, other than the changes mentioned above.

Question 5: 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.

59. Moving to telephone and video consultation changes the place where safeguarding occurs. Robust safeguarding processes have been developed to ensure that all women with a safeguarding risk are identified, regardless of age. Staff providing telephone consultations are trained to identify risk factors which make women socially vulnerable, this includes age under 18 years, child protection needs, domestic violence and abuse, mental health concerns, drugs and alcohol, sexual assault, coercion, child sexual exploitation, female genital mutilation (FGM), learning disability and modern slavery. All women under 18 have a safeguarding risk assessment,

as do any vulnerable adults. Clients having a risk assessment are also offered video consultations.

60. Early provisional information received from independent sector abortion care providers in England and Wales shows that the percentage of safeguarding referrals has increased since the introduction of telemedicine between March and July 2020 (Figure 9).



This may be due to an increased number of women feeling more comfortable disclosing information over the phone or by video consultation, as well as the overall decline in the number of women purchasing abortion pills online. This second cohort of women are more likely to be vulnerable. Providers report that longer conversations can take place over telephone, which increases the likelihood of disclosure.

61. From a harm reduction perspective, bringing more women into contact with the formal healthcare system provides an opportunity for professional safeguarding help and support. It also protects them from the current law which, should they access unregulated abortion, would criminalise them.

62. Women experiencing domestic abuse are sometimes unable to safely attend a hospital or a clinic, which was a feature of safeguarding support prior to telemedicine. One provider of unregulated pills has estimated that 1 in 5 women who request pills from them do so because they are a victim of domestic abuse. Since the introduction of this new pathway, requests for unregulated

medication have fallen by 88%. This is despite the rise in domestic abuse and coercive control during the pandemic and is a good indication that those women now feel regulated abortion care is accessible to them. Women's charities (such as Women's Aid and the End Violence Against Women Coalition) recognise this issue and supported amendments to the UK Domestic Abuse Bill 2020 to permanently introduce telemedicine abortion care for women suffering domestic abuse.

Question 6 - 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?

63. We know that people with a protected characteristic will sometimes experience greater difficulty accessing healthcare services, and that services need to be planned appropriately. The Public Sector Equality Duty (Equality Act 2010) applies to public sector authorities, including the NHS and local authorities who have a role in planning health services, and requires these organisations to eliminate unlawful discrimination, advance equality of opportunity between different groups and foster good relations[39]. Organisations must ensure that where discrimination against a group is identified, appropriate mitigations should be put in place.

64. We consider the use of telemedicine abortion care to have a positive impact on furthering access to abortion care services protected groups. Should the approval order be rescinded, the RCOG believes the Welsh Government has a legal obligation to assess and mitigate the potential impact this would have on these groups.

65. Many women face barriers to the traditional early medical abortion care pathway, this may be due to travel difficulties, family responsibilities, domestic abuse or coercive control or other reasons. Protestors outside abortion clinics negatively impact women attending appointments, but some women may be more affected by their presence, especially if they are a member of the same religious community.

66. Young women and girls may be more greatly disadvantaged by a return to the traditional model of care due to the cost of travel, being in fulltime education or work commitments. Travel to clinics may generally be impossible and interaction with healthcare professionals via the phone offers a pathway to treatment. Women from different religious or cultural backgrounds may have trouble accessing in-clinic care due to living arrangements and may face stigmatisation. We also

[39] UK Government. Equality Act 2010. [Available here: https://www.legislation.gov.uk/ukpga/2010/15/contents]

know that some disabled women may struggle to access an in-clinic appointment. Most women who have an abortion already have children, and therefore may have trouble arranging childcare, especially at short notice or at specific times when appointments are available.

Question 7 - 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?

67. Socioeconomic disadvantage is a key barrier to accessing healthcare services including abortion care. We consider that telemedicine has increased access to reproductive healthcare by removing the requirement to travel to a clinic. Generally, women who are the most deprived disproportionately have the highest need for abortion care, due to other barriers that they face.

68. The requirement to travel for in-person care presents several more financial issues to overcome, which impede access to care. This includes the cost of childcare, the cost of travel, work absence and the effect on a potentially already precarious employment or flexible contract. The requirement to commence the abortion procedure in the clinic, by taking the mifepristone, can also be inconvenient and potentially require further absences from work. The current arrangement allows women to take the medication at not just a convenient time, but a time when they are able to have an early medical abortion without negatively impacting other elements of their life, such as employment.

69. For those with a socioeconomic disadvantage, other factors may also impact their ability to be seen earlier in their pregnancy. Access to a treatment package sent in the post helps to alleviate these additional pressures.

70. Women living in remote, rural or island communities experience barriers to care. This is expensive, time consuming and further amplifies already existing disadvantages for those with a protected characteristic or who are at a socioeconomic disadvantage.

71. Women travelling long distance may be forced to stay overnight, which costs money, and due to the regimen of early medical abortion, would potentially mean they are required to take the second abortion pill while travelling back home, defeating the purpose of allowing home use of misoprostol, and causing symptoms in public. In addition, those women travelling after taking the

first abortion pill can also experience symptoms such as nausea, vomiting and bleeding.

72. Should telemedicine not be available to women in remote and rural communities, women are more likely to turn to an unregulated online source and thereby not engage with the formal health system, risking both criminalisation and poorly managed abortion and post-abortion care.

73. The introduction of the telemedicine model of care therefore resolves many of the barrier's women face by virtue of their location.

Question 8: Should the temporary measure enabling home use of both pills for EMA:	
Become a permanent measure?	x
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).	
Other [please provide details]?	

74. Given the added benefits outlined throughout this response, we believe that the current arrangements should become permanent.

75. In addition, the Welsh Government should consider removing the gestational limit at which telemedicine is permitted. In Scotland, the Government did not include a limit in their approval order, but instead referred to guidance issued by the Scottish Abortion Care Providers Network, which specifies an upper-gestational period of 11 weeks and 6 days. It is our view that this should be determined by clinical guidance and not law. An arbitrary legal limit will prevent innovation and reduce choice for women.

For further information please contact:
[information redacted]

WELSH GOVERNMENT CONSULTATION: TERMINATION OF PREGNANCY ARRANGEMENTS IN WALES

Wales Humanists Dyneiddwyr Cymru

Response from Wales Humanists, February, 2021

ABOUT WALES HUMANISTS

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

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

EXECUTIVE SUMMARY

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

RESPONSE TO CONSULTATION QUESTIONS

1. **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.**

Yes, it has had a positive impact.

Safety

Telemedicine (as introduced in 2020) is safer for women and girls than other forms of abortion.

Abortions have been performed legally in Wales for over 50 years and have a very high safety rate.One in three women will access abortion care during their life. For example, in 2019, there were 207,384 abortions performed in England and Wales with complications reported in 337 cases (1.6 per 1,000 abortions or 0.2%).[1] A study carried out by the University of Texas, published in the *British Medical Journal* in May 2017, found that in 95% of cases, women in Northern Ireland and the Republic of Ireland who used online-purchased abortion pills safely ended their pregnancies and did not require medical attention, and none of those who did require medical attention had any serious complications.[2] The study looked at data from 1,000 women between 2010 and 2012, who were less than ten weeks pregnant and had used the drugs misoprostol and mifepristone, both of which are used in abortions provided by the NHS. This evidence suggests that overall taking these pills at home is effective and safe and with only a slight increase in complication rate compared to NHS abortions. In 2017, most abortions were illegal in Northern Ireland and the purchasing of these pills online was a crime.

Moreover, the earlier an abortion is performed the less likely there are to be complications and therefore the safer it is. 30% of abortions in Wales have been performed before six weeks since the change in regulations, compared to only 13.5% beforehand.[3] Furthermore, 'between January to June 2020 (after telemedicine was introduced), 86% of abortions were performed at under 10 weeks. This compares with 81% in January to June 2019, an increase of 5 percentage points.'[4]

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

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

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

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

[3] BPAS, 'Pills By Post: Welsh Government's public consultation on continue home use of both pills for early medical abortion response guide' December 2020. https://www.bpas.org/media/3422/wales-ema-consultation-template-response.pdf

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

[5] *Ibid*

[6] *Ibid*

[7] *Ibid*

[8] *Ibid*

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

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

Accessibility

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

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

By enabling telemedicine in 2020, the evidence shows that there was an increase in service delivery even during the height of the first wave of the pandemic. The mean waiting times were 4.2 days shorter for women and girls using telemedicine than those attending clinics.[12] Acceptability among service users was extremely high with 96% of women and girls reporting they were satisfied with the service and 80% reported a future preference for telemedicine and none reported that they were unable to consult in private using teleconsultation.[13] The increase in procedures in March, April, and May 2020 compared to preceding years strongly suggest that abortion services were more readily accessible and that women and girls have benefitted from this change.

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[9] BPAS, 'Pills By Post: Welsh Government's public consultation on continue home use of both pills for early medical abortion response guide' December 2020. https://www.bpas.org/media/3422/wales-ema-consultation-template-response.pdf

[10] *Ibid*

[11] Lord, J, *et al* 'Early medical abortion: best practice now lawful in Scotland and Wales but not available to women in England' *BMJ Sexual & Reproductive Health* 2018; 44:155-158. https://srh.bmj.com/content/44/3/155

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

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

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

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

Convenience

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

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

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

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

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

have felt so intimidated by the presence outside they have asked for the abortion service to be withdrawn.'[16]

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

2. **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.**

Yes, it has had a positive impact.

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

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

3. **What risks do you consider are associated with the temporary measure? If youconsider that there are risks, can these risks be mitigated?**

As described above the temporary measure has proved to be safer, more accessible, and women report that safeguarding against coercion both by partners and anti-abortion protestors is improved under telemedcine compared to in-person appointments. Thus we do not consider there to be any risks associated with this measure.

4. **In your experience, have other NHS Wales services been affected by the temporaryapproval? If so, which?**

No

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

5. **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.**

No.

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

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

6. **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?**

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

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

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

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

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

7. **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?**

Women with lower incomes or who live in areas where they have little access to transport are disproportionately affected by the barriers to accessing in-person services. This means that these

women are more likely to delay appointments until later into their pregnancies and therefore are more likely to have complications. Telemedicine has reduced these barriers and therefore benefited women from more deprived backgrounds.

8. **Should the temporary measure enabling home use of both pills for EMA:**

Become a permanent measure.

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

[information redacted]

BSACP
BRITISH SOCIETY OF ABORTION CARE PROVIDERS

Submission to the Welsh Government consultation on home use of both pills for early medical abortion up to 10 weeks' gestation in Wales

February 2021

Background to the organisation making this submission

The British Society of Abortion Care Providers (BSACP) is the principal, authoritative Society for health professionals working in abortion care in the UK, its Crown Dependencies and its Overseas Territories. It aims to provide a supportive community to promote best practice in abortion care. It was formed in October 2015 and is a specialist Society of the Royal College of Obstetricians and Gynaecologists (RCOG). It is separate from the RCOG but works closely with it and with its Faculty of Sexual and Reproductive Healthcare (FSRH). Representatives of all devolved nations sit on its Council. Its membership comprises mainly doctors, nurses and midwives who deliver abortion care for the National Health Service (NHS) – whether in NHS settings or the independent sector. The three main independent sector providers (ISPs) are: the British Pregnancy Advisory Service (BPAS), MSI Reproductive Choices (MSUK) and the National Unplanned Pregnancy Advisory Service (NUPAS).

Global context

BSACP regards the temporary measures put in place for Wales by the Welsh Government in response to the coronavirus pandemic as a major contribution to the public health which recognises abortion as an essential service. Sweden was already offering telemedicine and mifepristone at home within an ongoing clinical trial in Stockholm before the pandemic.[1] Ireland was the first country in the world to approve telemedicine for abortion during the pandemic; it did this by confirming on 26 March that the existing law permitted it.[2] England followed four days later and Wales and Scotland the day after that with specific regulations (https://bsacp.org.uk/resources/covid-19-advice/). The only other countries known to have taken such action, including the treatment itself, are South Africa on 3 April,[3] France on 10 April[4] and Moldova on 18 August.[5] Great Britain has come to be cited around the world as an example of healthcare excellence with respect to the introduction of these measures .[1 6-12]

An integral part of wider changes in service delivery

Remote consultations and the ability to take both medicines at home are a logical response to the pandemic, integral to other changes in the way of working. These measures help to limit the spread of infection and allow women[a] access to abortion care if they are self-isolating.[13] Even before the pandemic, NICE had recommended that the NHS should consider abortion assessments by phone or video call, and in a range of settings, to meet the needs of women.[14] In its systematic review, NICE

[a] Within this submission we use the term woman. However, it is important to acknowledge that it is not only people who identify as women for whom it is necessary to access women's health and reproductive services in order to maintain their health and wellbeing. Abortion services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

found that community prescribing and telemedicine improved access to abortion services and facilitated a more patient-centred approach to care with no difference in outcomes.[15] NICE noted that telemedicine is likely to improve access, especially for vulnerable groups.[16] Moving away from a 'seen and examined' regulation is progressive and allows both patient and clinician much greater flexibility. Early medical abortion (EMA) has been subject to multiple innovative service modifications since the pandemic struck.[17] For example, the concept of 'resource stewardship' including 'no-test' medical abortion was rapidly developed.[18]

BSACP believes that these changes combined have been responsible for the ability to meet demand for the service during a pandemic and for the highly significant downward shift in gestation reflected in the England and Wales abortion statistics – 27% of medical abortions at under 6 weeks in Q1 and Q2 of 2020 cf. 16% for the same period in 2019.[19] By June 2020, more than a half of women undergoing medical abortion were taking both pills at home.

Scope of submission

As the consultation requires, the main part of the BSACP submission is about the impact of the temporary measures on the delivery of early medical abortion in Britain. Our submission draws heavily on high quality scientific evidence; these studies have all been designed, conducted and written up at an intense pace during the pandemic. The submission also draws on soundings from our members specifically with respect to the current consultations and also from two previous parliamentary consultations we have responded to (see https://bsacp.org.uk/resources/bsacp-submissions-to-formal-consultations/).

Effectiveness

In this and the following three sections of this submission, we present in detail the findings from the national cohort study by Aiken et al of data from BPAS, MSUK and NUPAS.[20] The study sample represents 85% of the total number of medical abortions performed in England and Wales during the study period. The sample includes all patients who accessed an early medical abortion (EMA) from these three providers during the two months before and two months after the service model change respectively. A comparison was made of 22,158 women having an EMA between 1 January and 1 March 2020 (the traditional cohort) with 29,984 accessing an EMA between 6 April and 30 June 2020 (the telemedicine-hybrid cohort). In the latter cohort, 61% of patients were treated entirely by telemedicine. This study is not only scientifically robust but also reports on the real-world experience of how the entire service was delivered.

Patients in the latter cohort received care using no-test telemedicine if they had a low risk of ectopic pregnancy and their self-reported last menstrual period (LMP) indicated a gestation of less than 10 weeks. Rates of successful medical abortion were found to be high under both service delivery models: 98.2% in the traditional cohort compared to 98.8% in the telemedicine-hybrid cohort. Within the telemedicine-hybrid cohort, rates of successful medical abortion were significantly higher for the telemedicine group compared to the in-person group (99.2% v 98.1%). This may be due to the ability of women to better control the timing at which they took their medicines, using regimens with more optimal intervals between the mifepristone and misoprostol.

These findings confirm the results from the previous study from Scotland about the high efficacy of taking misoprostol at home in patients who had been seen at a clinic and had a scan.[21] A recent prospective cohort study of 663 telemedicine abortions up to 12 weeks' gestation in the NHS in Scotland reports a similar high effectiveness.[22] Follow-up with completed questionnaires at both day 4 and day 14 post-abortion was achieved in 605 women (91%). Outcomes were verified by cross-linkage with hospital and community service records. 522 of the 663 women (79%) had their gestational age determined by LMP alone and 650/663 (98%) had a complete abortion.

Safety

In the national cohort study, significant adverse events in both cohorts were rare.[20] Haemorrhage requiring transfusion was reported in 0.08% of cases in the traditional cohort and 0.04% of cases in the telemedicine-hybrid cohort. No cases of significant infection resulting in hospital admission, major surgery or death were reported.

The overall incidence of ectopic pregnancy was equivalent in both cohorts: 0.2% in the traditional pathway and 0.2% in the telemedicine pathway. Thus, the very low incidence of ectopic pregnancy was no different in the modified care pathway from traditional in-person care with a routine ultrasound scan, meaning there is no evidence that the telemedicine model is missing this complication that can arise in any pregnancy.

There were 11 cases (0.04%) in the telemedicine-hybrid cohort in which the gestational age at abortion was subsequently reported as being greater than the expected 10 weeks. In all these cases, the medical abortion was completed at home without additional complications. Whilst these women would have been offered a surgical abortion had the true gestation been known, given the

restriction in the English approval order, that restriction is not supported by clinicians and has no evidence base or rationale to support it. Indeed, evidence shows that self-managed abortion up to 23 weeks is safe and effective.[23] BSACP believes that the decision about what method (surgical or medical) and location (home or clinic) is best made by informational exchange between women and their clinical team, having weighed up all the circumstances of the individual concerned. Also, it is best managed through clinical guidelines and not via rigid legal restriction which is incompatible with personalised care.[24] The cohort study from Scotland, where there is no gestational limit applied by the approval order, showed few complications, with zero cases of haemorrhage requiring transfusion and zero cases of infection requiring intravenous antibiotics.[22]

The lowered gestation at treatment brought about by increased use of the new model of care will have an overall beneficial effect on women's health as both morbidity and mortality are known to be lower the shorter the gestation.[25] It will also be less distressing for women, both because the pregnancy itself is less advanced and because any underlying symptoms of pregnancy such as nausea, which can be debilitating, will have less time to develop.

Accessibility, convenience and waiting times

A large majority of patients who had a telemedicine abortion from the independent sector providers (ISPs) opted to have the pills delivered by post.[26] [27] A minority opted to travel to a clinic to collect the pills. The latter choice was made by, among others, those who did not want to incur delays in the postal service, those for whom a delivery might have been received by a member of the household the patient did not want to disclose the abortion to or those who had concern about the package being delivered to the correct address.[26] In the NHS study in Scotland, 65% of patients reported the ability to collect medication from a pharmacy to be of high importance to them.[22]

The new pathway gives women greater choice about when to start their EMA. By not being tied to a clinic appointment date, women can decide to begin the process over the weekend or at a particular time that is convenient for them.

Women identify minimal delay as a high priority in abortion services and find delays distressing.[28] The national cohort study showed improved access after introduction of the temporary measures.[20] Mean waiting time to treatment declined from 10.7 days in the traditional pathway to 6.5 days in the telemedicine-hybrid cohort. This fall in waiting time meant that gestational age at treatment also declined, resulting in 40% being at 6 weeks or less compared to 25% in the traditional pathway. This

highly significant improvement in accessibility is a major benefit of the new measures which allows treatment to run more smoothly and reduces women's distress.

Data collected by the three main ISPs and analysed by the RCOG, confirms this highly significant fall in waiting times with the temporary measures in place. The longest waiting time in 2019 was 15.34 days and the shortest waiting time in 2020 was 5.48 days. Reduction in waiting times has beneficial effects only; there is no waiting time that is too short.[29]

Another form of evidence on access comes from a study on the use of online telemedicine by British residents. A highly significant decrease in requests was seen by Women on Web following the introduction of the temporary measures.[30] This decrease points not only to the removal of access barriers posed by COVID-19 but also to pre-existing barriers. The modified model of care allows more women to access abortion care through official health sector channels.

Acceptability

Detailed acceptability studies from both BPAS[27] and MSUK[26] draw on samples of roughly 1 in 10 of all those having EMAs with these ISPs, each study containing more than 1,000 subjects. The BPAS study includes all those having the pills at home; the MSUK includes only those who had their consultation via telemedicine.

Overall satisfaction with the treatment was more than 95%. 80% or more of patients were satisfied with pain control measures. In the MSUK study, 99% felt they had had an opportunity to ask questions, 92% felt they had had enough information and 87% had no concerns about the safety of taking the medicines outside a health facility.[26] In the BPAS study, 78% would have an EMA using a telephone consultation in the future, 78% would have both pills at home and 69% would have their medicines delivered by mail.[27] The Scottish cohort study, with its 91% response rate to follow-up at two points in time, reported that 95% of women found the overall experience as somewhat/very acceptable, 87% found the remote consultation acceptable and 71% would opt for such a consultation again if it were to be needed.[22]

Privacy and confidentiality

In the MSUK study, 95% felt they were able to talk privately. BSACP supports the ability of patients to opt to have their consultation in a place of their choosing away from the clinic. Those under coercive control are best protected by being free to choose their preferred time and place to ensure

they are alone and cannot be overheard. Furthermore, protests outside clinics can be intrusive and distressing and avoiding them is one of the reasons women cite as to why they pursue telemedicine by email where remote clinician-to-woman care is not available.[31]

Providers and services

The temporary measures have had multiple effects on those involved in delivering abortion services; on balance these have been overwhelmingly positive. Some BSACP members report personal challenges in the wholesale switch from face-to-face to remote consultations but they have embraced it in order to put their patients first. Members believe that the temporary measures allow much more flexibility in running services and they improve overall service efficiency.

A particular example of benefits to providers has been the facility to prescribe from home. Our members who work for MSUK pointed out the following non-COVID related benefits of the measures:

- Greater flexibility in childcare arrangements for the 58% of doctors who have children
- Ability to continue working when suffering from a mild viral illness/injury or long-term health problems
- Obviating a commute to the workplace

There are financial savings to be made from the lower gestations associated with the modified care pathway and from the fact that more women choose not to have surgery. Extrapolating from the estimates of the NICE guideline,[14] about £6.7 million per year is being saved in England under the temporary measures.

Possible concerns

We will consider four potential concerns that might be raised about the modified management of those undergoing EMA: a) uncertain gestational age due to lack of routine ultrasound scanning, b) late diagnosis of an ectopic pregnancy, c) difficulty in perception of non-verbal cues relevant to an unstable decision about abortion and to safeguarding issues and d) committing to initiation of the abortion process and taking the medicines away from medical supervision.

With regard to a), as mentioned above in the Safety section, the 11 cases in the national cohort telemedicine-hybrid group that were at more than the expected 10 weeks all completed the abortion at home without additional complications.[20] With regard to b), although routine ultrasound

scanning is not necessary, clinical guidance for remote care excludes women who have risk factors for or symptoms/signs suggestive of an ectopic pregnancy. Routine scanning in symptom-free women without risk factors is questionable as it may aid detection of some cases but falsely reassure others that a pregnancy is intrauterine.[32] The absolute incidence of ectopic pregnancy in those undergoing abortion is known to be ten times lower than that in the general population.[33] The general population are not seen in person and scanned unless they have symptoms of an ectopic pregnancy. There is no clinical justification for maintaining an inconsistency in care between those continuing their pregnancy and those choosing EMA.[20]

Regarding c), the experience of BSACP members is the converse; their experience is that women can talk more freely and openly when consulting over the phone than in a clinic. Many people are intimidated by medical consultations and, with abortion care being so intensely personal and private, face-to-face discussions can be perceived as threatening. Many women expect to be judged, given the stigma attached to abortion care[34] – an expectation reinforced by the frequent protests that occur outside abortion clinics (https://bsacp.org.uk/wp-content/uploads/2020/10/BSACP-Position-Statement-Protests-18082020.pdf). In contrast, people are accustomed to talking over the phone and when consultations are conducted from the privacy and safety of their own home, they are more likely to be open and honest, rather than feeling obliged to offer answers they perceive to be expected of them. This impression is borne out by consultations often taking longer over the phone – as the patients simply talk more – and that rates of identification of safeguarding issues have increased.

Finally, with respect to d), it is clear from experience so far that women are well able to make the decision to swallow the mifepristone by themselves in the privacy of their homes. Taking both mifepristone and misoprostol at home has been routine practice across the world for many years and has an excellent safety record.[35] [36] The deregulation of mifepristone in Canada in 2017 has not resulted in a clinically significant increase in abortion complications, continuing pregnancy or adverse events.[37] Mifepristone is a very safe medicine. Table 1 shows numbers of spontaneous adverse drug reaction reports for mifepristone, sildenafil (Viagra) and paracetamol.

Table 1 Drug Analysis Profile data from UK Yellow Card Scheme for the years 2000 – 2019

Drug	Classification	Serious ADR reports	Fatal ADR reports
Mifepristone	POM	253	17
Sildenafil	P	892	170
Paracetamol	GSL	5598	545

Source: https://yellowcard.mhra.gov.uk/iDAP/

Note: Please read the important caveats about these data on the website. The existence of an adverse drug reaction report in the iDAP does not necessarily mean that the medicine has caused the reaction. It is not possible to exactly quantify the safety of different medicines by comparing the numbers presented in the iDAPs.

Effect on other NHS services

We have not received any hard data on this so far. BSACP considers it likely that there have been reduced referrals to Early Pregnancy Units as those previously with pregnancies too early, or where the pregnancies were non-viable, will simply be managed via telemedicine.

Information on risks given to women

Information availability has increased rapidly during the pandemic. BPAS includes the risks and complications in its information about Pills by post: https://www.bpas.org/abortion-care/abortion-treatments/the-abortion-pill/remote-treatment/. MSUK includes a series of videos in its information about At Home Abortion Pills: https://www.msichoices.org.uk/abortion-services/online-medical-abortion/ .

BSACP is satisfied that patients who opt to receive their EMA via the modified pathway are being given access to high-quality information and support. An example of NHS information for those in Lothian, Scotland, is at: https://www.lothiansexualhealth.scot/pregnancy-planning/abortion-services-during-covid-19/. There was no difference found in recall/acceptability of Lothian service users who had the information face-to-face or via video.[38] In Wales, the video made by the Beth service in Gwent has received acclaim: https://abuhb.nhs.wales/community-services/sexual-health-services/sexual-health-accordion/think-you-may-be-pregnant/.

As part of the pathway change and to improve the process of gaining informed consent, information (links and documents via e-mail) is now given at the initial presentation so the patient has a chance to read and think of questions prior to the telephone consultation. Previously, this would have been

conveyed in a face-to-face consultation, where people are often nervous, may be reticent to ask questions, and often may not be receptive to retaining information as they are in an unfamiliar environment, stressed and expecting to be judged.[39]

In the MSUK study, 92% of women undergoing telemedicine EMA reported that they 'definitely' had enough information to take the medication by themselves.[26]

Safeguarding

BSACP is familiar with the phenomenon of reproductive control[40] and with domestic violence – the two overlap and probably have similar antecedents. Survivors of domestic abuse in the UK, especially those living with their abuser, have reported worsening of the abuse during the pandemic.[41] The United Nations has termed this high prevalence of domestic violence, exacerbated by lockdown, the 'shadow pandemic'.[42] Forced sex and contraceptive sabotage are two of the behaviours that those with unintended pregnancies who present to our members are describing. The vast majority of cases of coercive control involve men controlling women and our experience is that coercive control is more commonly seen in the form of denying a woman access to healthcare and abortion than attempting to force her to have an abortion against her will. It would appear that there is a direct correlation between the imposition of social distancing measures and threats to women's wellbeing, health and safety in this respect. Remote consultation is essential for these women as, during lockdown and in higher-tier restrictions, they find it hard to leave their house without explanation. Although this situation may ease after the pandemic, allowing women to choose options of care makes it more flexible for those who are in a form of long-term lockdown.

We understand that an audit done during the first three months of their Pills by Post service showed that 1 in 10 clients at BPAS underwent an enhanced safeguarding risk assessment. This is a 12% increase compared to March 2020. Data from MSUK show a 27% increase in the detection of safeguarding issues since the start of the pandemic.

BSACP members expressed their view that anti-abortion groups are wrong to state that safeguarding can only be provided in face-to-face consultations. Providers have protocols in place to ensure that a woman is able to talk in private and is not being coerced. It seems likely that this is easier to achieve where a woman can use her own phone in private than when she has to attend a clinic where a coercive partner is aware of, or indeed even present at, her consultation. BSACP believes that some women will feel better able to talk freely when they are in their own environment than they may do

when in a clinic environment that might feel intimidating. MSUK reports that three of its major safeguarding cases from 2019 – i.e. before the pandemic – were identified during a telephone consultation. These were the rape of a 12-year old girl by her stepfather and uncle, the identification of a human trafficking ring from which three women were rescued following a multi-agency response and a 10-year old who was raped by her stepfather who could only be traced by her call.

We anticipate that abortion services will continue to offer in-person care where remote consultations raise safeguarding concerns. This gives women choice and also allows providers to give the most appropriate care to every individual.

Equality considerations

As always, the impact of an unwanted pregnancy on marginalised individuals and communities is proportionately greater. Remote consultations are beneficial for those who would otherwise need an extended period of childcare to attend an appointment; this is particularly relevant for those parenting a child with special needs. Consultations in which the patient and practitioner do not share a language always bring additional challenges. However, in many settings, use of phone interpreters has been common practice for some time. The patient and practitioner not being in the same physical space is somewhat more challenging but the use of video-consulting options will assist once these become universally available.

BSACP believes that some younger women will have difficulties travelling from the family home and that telemedical services will have been particularly beneficial for them as they are under the scrutiny of parents, who may be unaware of their sexual activity. BSACP believes that advantages for many disabled people will apply too in that journeys to health facilities and potential difficulties with access to buildings will have been avoided. These issues may have been exacerbated during COVID restrictions but are ever-present in these particular groups.

BSACP believes that the Women on Web study,[30] mentioned above, most likely shows that particular groups have had difficulty accessing EMA up to the onset of the pandemic and now feel more comfortable accessing the modified pathway. These groups will include those with mental health problems, single-parent families, those with disabilities, those living in poverty, sexual assault survivors, those living on islands or in very rural locations[43] and others particularly with intersecting issues.

Ten-week limit

The temporary measures impose a 10-week gestational limit, as did the previous regulations for misoprostol. This is an additional restriction which is not evidence-based. There has been no suggestion that clinicians have been conducting medical abortions inappropriately. In Scotland, no such restriction was brought in; rather the regulation refers to clinical guidance issued by the Scottish Abortion Care Providers Network. This currently advises an upper gestational limit of 11 weeks and 6 days and is in keeping with modern clinical practice. BSACP views the imposition of an arbitrary but fixed gestational limit as problematic as it removes choice and takes decision-making away from the woman, as advised by her clinical team. It also adversely impacts the facility-based practice of medical abortion at higher gestations by insisting that mifepristone is swallowed on the premises and/or that women have to administer misoprostol in a clinic and then get home before pain and bleeding get too intense. BSACP sees arrangements aligned with those in Scotland as preferable and hopes that the Welsh Government will follow the lead of the Scottish Government.

Making the measures permanent

In the longer term, BSACP maintains its belief that abortion should be decriminalised.[44] BSACP notes that restrictions on the storage and community prescription of mifepristone in place over the last 30 years have prevented use of the drug for emergency contraception; mifepristone has been known to be more effective than hormonal methods since 1992,[45] thus many unintended pregnancies (and abortions) could have been averted if it had been available for this use over these decades. There is a general point here too: unduly strict regulation often has harmful effects on patients.

Abortion services must be seen in the wider context of the health service response to the coronavirus pandemic. There has been widespread blue-sky thinking, innovation and introduction of new ways of working.[46] The pace of this work has been unprecedented despite the intense pressures of working in a pandemic. NHS England and Improvement has set up the national Beneficial Changes programme to identify these innovations and how they have improved delivery of healthcare.[47] The Beneficial Changes Network and Accelerated Access Collaborative are working together on this. Two emerging themes relevant to this submission are digitisation of services and person-centred care. There is much more to be done, for example in building video consultation and electronic prescribing capacities in all relevant health facilities.

The use of remote consultations has been adopted by most services and has transformed the face of healthcare. Routine scanning has been widely switched to scanning when clinically indicated.

Delivery of medicines by courier or mail or collection at service provider facilities, pharmacies or other locations has been seen in many different services. All the advantages of telemedicine and 'click and collect' are applicable generally and are not confined to the exceptional times of a pandemic. This has already led to these new ways of working becoming embedded in health service delivery even before the Beneficial Changes programme has reported its findings.

Although 'no-test' EMA has been widely adopted in abortion care, this change in routine practice does not depend on the temporary measures. Intimate examinations should be kept to a minimum; given the high degree of accuracy in estimating gestation according to date of LMP,[48] it is highly unlikely that abortion providers will revert to routine ultrasound scanning. Requiring a woman to attend a clinic merely to swallow a pill would be unreasonable.

We can understand how the emergency measures for abortion care came to have a sunset clause. However, the landscape is now completely different, with almost one year of experience of being able to work much more flexibly and especially in light of the newly published safety data. The results of the national cohort study show that there is no need for routine scanning prior to EMA and that women can be 'trusted' to use abortion pills without direct medical supervision. A telemedicine pathway for EMA facilitates a shorter wait for the procedure, with equivalent effectiveness and safety and high acceptability.

Within the current outdated legal framework of our jurisdiction, BSACP believes that remote consultations and the ability for patients to take both pills at home should remain an approved and valid way of working beyond the pandemic. This fits with a human rights imperative and is a critical step towards complying with binding international legal obligations.[6] Telemedicine demonstrably enhances people's autonomy.[49] We would go as far as to say that reversion to the previous regime would be severely retrogressive and contrary to scientific evidence and medical advice; it would also suggest underlying political motivation to restrict access to abortion care. Not to make the measures permanent would also run counter to the efforts of NHS England's Beneficial Changes programme to embrace and adopt innovations that are seen as greatly beneficial to healthcare delivery.

In sum, BSACP believes that there is overwhelming support on scientific, clinical, social, economic, legal and ethical grounds for these measures to be made permanent.

22/2/2021

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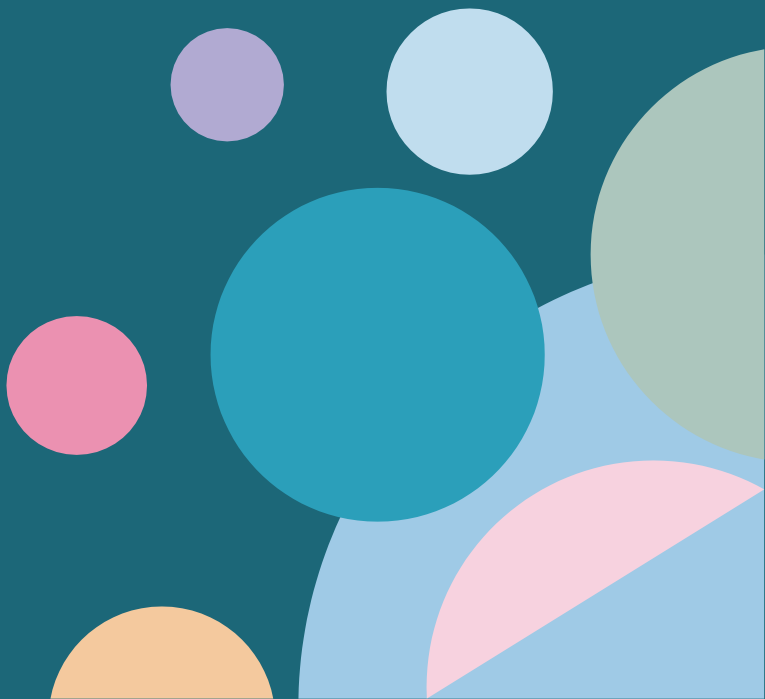
WOMEN'S HEALTH CROSS-PARTY GROUP

RESPONSE TO THE WELSH GOVERNMENT'S CONSULTATION ON TELEMEDICAL ABORTION

WRITTEN IN COLLABORATION WITH

BPAS

British Pregnancy Advisory Service



BACKGROUND

ABOUT US

The Women's Health cross-party group (WH CPG) first met as the Abortion and Reproductive Choice cross-party group to discuss abortion provision in Wales in 2018. Formed by MSs from Labour, Conservatives, and Plaid Cymru, and supported by a large number of clinical experts and women's health campaigners from across Wales, our initial focus was to understand current gaps in Welsh abortion and reproductive health provision and to improve future care. However, in 2019 it was decided that the remit of the group should be expanded to encompass the broad range of health issues currently facing Welsh women and the group was formally constituted as the Women's Health Group. A full list of member organisations can be found at the bottom of this report.

The aim of the Group is to improve the healthcare experience of Welsh women, ensure that they are listened to and that they have access to comprehensive healthcare. The breadth of clinical expertise, healthcare stakeholders and patient experience that are represented in this CPG have enabled us to create meaningful change on several key issues.

COVID-19

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

CLINICAL GUIDANCE

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

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

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

CHANGES TO LICENSED PREMISES

Under the Abortion Act 1967, in Wales abortion treatment may only be provided in NHS hospitals and on premises licensed for the purposes by the Minister for Health.

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

On the 31st March, the Welsh Government introduced a temporary approval, enabling women and girls to take both pills for Early Medical Abortion (EMA) up to 9 weeks and 6 days gestation in their own homes, following a telephone or e-consultation with a clinician, without the need to first attend a hospital or clinic.

THE CONSULTATION

The current arrangement was put in place during the pandemic to reduce the risk of transmission of Covid-19 and ensure continued access to abortion services. It is currently time-limited for two years, or until the pandemic is over, whichever is earliest.

The Welsh government is currently consulting on whether to make permanent the current temporary approval allowing for home use of both pills, mifepristone and misoprostol, for Early Medical Abortion at Home for all eligible women in Wales. The scope of this consultation does not extend to other abortion-related matters, including the wider legal framework.

Both Scotland and England are conducting similar consultations.

CROSS-PARTY GROUP POSITION

The Women's Health Cross-Party Group fully supports the use of telemedicine and legal provision to allow mifepristone for home use in Wales and across the UK. Our lay members provide abortion care across Wales, and the work done by the WH CPG in 2019 has focused on the safe, effective, accessible provision of abortion care. The impact on abortion care in Wales of this change has been large – it has reduced waiting times, reduced gestation at treatment, removed pressure on primary care services to sign forms or refer abortion clients, and enabled women in more rural and remote parts of Wales to access care in a timely fashion.

We ask the government to make the provision of mifepristone for use at home permanent.

CONSULTATION QUESTIONS

QUESTION ONE: IMPACT ON SAFETY, ACCESSIBILITY AND CONVIENIENCE

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.

SAFETY – POSITIVE IMPACT

Although no medical procedure is without risk, abortion is a safe procedure, and in all instances, safer than continuing the pregnancy to term. Abortion is safer for women the earlier it is performed. The introduction of telemedicine has resulted in a reduction of average gestations, meaning abortions are being performed earlier than ever before.

Both BPAS and NHS-led services in Wales have experienced large declines in waiting time since the change in regulation allowing Telemedicine. In 2019 a review of abortion services commissioned by

the Cross-Party Group on Women's Health found that many abortion services in Wales operated only a day or two a week, and that waiting times from contact to treatment averaged around 17 days. Since the change in regulation, waiting times in these services have declined to under 5 days, which is within NICE and medical guideline targets.

A recent cohort study from the University of Texas using data from BPAS, MSI Reproductive Choices, and NUPAS covering 50,000 abortions in England and Wales between 2019 and 2020 found that mean waiting times were 4.2 days shorter after the change in regulation and 40% of treatments were provided at ≤6 weeks' gestation, compared to 25% prior to the change. This increase is significant at both an individual and population level. The earlier an abortion can be performed when a woman knows she does not wish to continue the pregnancy, the greater the protection of women's health. The full paper has been peer-reviewed and published by the British Journal of Obstetrics and Gynaecology, and is available here - https://dx.doi.org/10.2139/ssrn.3742277.

Furthermore, recent DHSC data shows that since the introduction of telemedicine, in Wales 30% of abortions (provided by both the NHS and BPAS) are now performed before 6 weeks' gestation, compared to only 13% in the same period in 2019 - when telemedicine was not in place. Data from the British Pregnancy Advisory Service for the period of April - July 2020 shows that the risk of complication for Early Medical Abortion declined compared to the same period in 2019. Risk of a continued pregnancy after treatment has been administered also declined from 1.12% to, 0.28% compared to the same period in 2019. Similarly, the risk of major complications also fell by two thirds, from 0.09% to 0.03%.

These figures potentially reflect the fact that the introduction of telemedicine has significantly shortened waiting times for treatment and allowed women to choose the best time for them to start the procedure. Telemedical abortion care has meant that, rather than women having to wait for an in-clinic appointment for the first medication that fits around their commitments, they are able to start taking medication as soon as it's convenient for them – making abortions safer and better for women.

ACCESSIBILITY AND CONVENIENCE OF SERVICE – POSITIVE IMPACT

We know that for many women, being required to take medication in a licensed clinic or hospital is difficult. Clinics and hospitals can be far from a client's home, they need to take time off work, associated travel and childcare costs can be high, appointments can be lengthy because of the legal requirement for two doctors to authorise the abortion, and because of the requirement to take mifepristone in-clinic and the second set of pills 24-48 hours later, a woman cannot choose when she passes her pregnancy.

There are also specific challenges that the women of Wales face when trying to access abortion care. The 2019 WH CPG review of abortion care in Wales detailed how women who lived in more rural or remote areas (particularly those in the North or South West of Wales), have previously struggled to access care because of insufficient public transport or lack of access to private transport. As a result, the services that have provided the highest proportion of postal abortion treatment are those where clinic attendance can place a real burden on women – in Betsi Cadwaladr and Hywel Dda University Health Boards.

Culturally, abortion has the potential to cause issues for women living in more remote or rural areas. Women who live in smaller or more close-knit communities may be less able to travel to appointments discreetly due to the time needed to be away from home and the likelihood of meeting people they know on the transport or in the hospital. In smaller communities, accessing sensitive

medical care confidentially can also be difficult – particularly where referral into abortion services or signatures for HSA1 forms may be needed. This can delay or prevent access to care locally.

Prior to the change in regulation, women were allowed to administer misoprostol at home. However clinically, women may experience side-effects after administration of mifepristone in a clinic – including nausea, vomiting, or bleeding. Women living in rural or remote areas will then have to travel while experiencing symptoms, which is particularly problematic if they are driving long distances.

We also heard that some women, particularly those in Aneurin Bevan University Health Board (and, in recent history, Cwm Taf Morgannwg), have previously been required to attend multi-day appointments within the service or via GPs, in order to obtain the required signatures for the HSA1 abortion form – and as a result, delaying abortion treatment and creating further barriers for women trying to access care. NHS providers report that the change in regulation has allowed them to do this work behind the scenes remotely, meaning women are not delayed or forced to attend unnecessary appointments in order to access the care they need.

Office for National Statistics data shows that in 2019, an estimated 50,000 people in Wales were employed on zero-hour contracts, the highest percentage of people of any region in the UK. The insecurity of zero-hour contracts, often combined with a lack of sick-pay, means that workers on these contracts who need abortion treatment may delay the first in-clinic appointment if it clashes with their work hours, for fear of losing wages or their jobs. Telemedicine allows these women to access treatment as soon as possible whilst enabling them to manage treatment around their working hours.

Telemedicine removes barriers for women and allows them to access care that fits in with their lives, whilst ensuring they are treated by trained professionals and provided with the support they need.

Following the roll-out of their Pills by Post service BPAS conducted a service evaluation with 1333 clients. The full paper is available here - https://authorea.com/doi/full/10.22541/au.160691768.87050587. Key findings included:

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

QUESTION TWO: IMPACT ON SERVICE DELIVERY

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.

The temporary measure has had a positive impact on the provision of abortion services for those involved with service delivery.

In November 2020 the Women's Health CPG wrote to the Deputy Chief Medical Officer, Chris Jones with information of evidence presented to us in a meeting of June 2020. In this meeting we heard from Welsh abortion providers who reported that the change in regulation to allow telemedical abortion has been revolutionary for them – it has enabled them to streamline the process for clients, helped to avoid delays, reduce waiting times and waiting lists, and reduce the gestational age of terminations and thus the complication rate.

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

Telemedicine in Wales has been accompanied by changes in some areas to ensure that the legally-required signatures for abortion forms can now be provided in-service. This means that there is less pressure on sexual health, contraceptive, and GP services – and less chance of delays for women who present without the required signatures.

Prior to the change in regulations, clients were required to attend services for prolonged periods – for face to face consultations, scanning, two doctors' signatures, and administration of mifepristone. Although the change in regulation concerns only the administration of mifepristone, the change has enabled providers to reconsider how services are provided and determine for themselves the most effective use of workforce and accessibility needs locally.

According to the Aiken cohort study (https://dx.doi.org/10.2139/ssrn.3742277), the change in regulation has also led to a reduction in gestation at time of treatment, coupled with no changes to complication rates. Analysis indicates that this will, in the medium to long term, reduce the costs of providing an early medical abortion service – enabling Health Boards to focus on using money to improve service provision e.g. for later or more complex care, further reduction in waiting times, better provision of contraception, or wider STI testing.

Although guidance was updated at the same time to recommend a 'scan as indicated' model for women early in pregnancy, this is not something governed by this consultation, nor should it be. The only places in the world that have considered implementing the requirement to undergo ultrasound scanning in law are in the USA, where the ultimate aim is to deter women from accessing abortion care at all. Government should not play a role in clinical best practice, and specifically not implement rules which result in requiring women early in pregnancy to undergo transvaginal scanning, which can be invasive and physically and emotionally challenging for clients.

QUESTION THREE: RISK

What risks do you consider are associated with the temporary measure? If you consider that there are risks, can these risks be mitigated?

MEDICAL PROCEDURES AND RISK

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

Prior to this change in regulation, women were administering misoprostol in their own homes and, for a longer period, have been passing their pregnancies at home after Early Medical Abortion or medical management of miscarriage. Although complication rates are low for both procedures, they are more likely to occur during this stage of treatment rather than at the point of mifepristone administration. Ultimately, therefore, risks of serious complications such as haemorrhage (2 in 1000) which require hospital treatment were already present, recognised, and treated prior to the change in regulation.

The Women's Health CPG has heard from providers in Wales who have worked hard to establish a safe, effective, and accessible telemedical abortion model at a time when all other healthcare has been under substantial pressure. The work of providers and the change in regulation has meant thousands of women in Wales have been able to access safe care that otherwise they may have struggled to obtain.

LATE FOR LMP PRESENTATIONS

Since the change in clinical practice to rely on Last Menstrual Period (LMP) rather than a scan for determining gestational age, there have been a very small number of cases involving gestations outside the 10-week limit for pills at home. The initial indication was that this risk would be around 1 in 1000 – 0r 0.1%. The risk now appears to be significantly lower, at 0.04%. This means you would need to compel 10,000 women to undergo a transvaginal or abdominal scan – which women often find invasive and unpleasant – in order to prevent four cases of a woman being treated whose pregnancy was in excess of 10 weeks.

This consultation is rightly only concerned with *where* the first part of an Early Medical Abortion is taken. Decisions about scanning are not within the purview of this consultation or subject to Government approval, but instead are based on clinical guidelines and best practice. Guidance that routine scanning is not necessary to provide a safe and effective abortion service has been in place since 2011 in RCOG's Guidance for the Care of Women Requesting Induced Abortion.

ECTOPIC PREGNANCIES

The prevalence of ectopic pregnancy in the abortion population is very low – in the Aiken cohort study (https://dx.doi.org/10.2139/ssrn.3742277) 0.2% of clients (1 in 500) both before and after the change were diagnosed with an ectopic pregnancy. This compares to 1 in 90 in the general population.

As part of their consultation with clients, abortion providers ask questions to determine the risk of an ectopic pregnancy – including questions about abdominal pain, bleeding, historic of ectopic pregnancy, and history of caesarean section. For those women where the provider identifies a risk of an ectopic pregnancy, they are brought in for a ultrasound scan before treatment is provided.

Outside abortion care, ultrasound scans are not provided as a screening tool in the general population, despite their higher incidence of ectopic pregnancy. In the case of continuing pregnancies, scans are only provided as indicated – where signs and symptoms suggest a need. In this way, the new abortion care pathway is the same as provision for women continuing their pregnancies.

Diagnosis of an ectopic pregnancy is not always straightforward within abortion care, regardless of whether or not a scan is provided. Abortion is provided at such early gestations that evidence of intrauterine pregnancy may not be seen on an ultrasound scan. NICE guidelines are clear that evidence of an intrauterine pregnancy on an ultrasound scan is not required before treatment. In all methods of care, therefore, there is a risk of a woman presenting with an ectopic pregnancy after care has been provided. Regardless, the risk is very low and follow-up care recommends presentation to Early Pregnancy Assessment Units for treatment.

The Aiken cohort study found that 0.01% of clients in the previous pathway were treated for an ectopic pregnancy after treatment (which included a scan), compared to 0.03% in the new pathway.

QUESTION FOUR: EFFECT ON OTHER SERVICES

In your experience, have other NHS Wales services been affected by the temporary approval? If so, which?

The Aiken cohort study (https://dx.doi.org/10.2139/ssrn.3742277) has found that there was no difference in outcomes between the previous pathway and the new, telemedical pathway. This includes no increased risk of serious adverse events which would require hospital care (0.04% in the previous pathway, compared to 0.02% in the new pathway), and indeed a slight increase in success rates (98.2% compared to 98.8%) which would likely have a positive impact on NHS abortion services. The evidence we have heard from Welsh abortion providers is that they are providing fewer Evacuation of Retained Products of Conception procedures – reducing the length of surgical lists and minimising the number of women who have to present to gynaecological services.

The administrative changes that the temporary approval has allowed for have also created positive effects for NHS Wales Service. Some abortion services in Wales operate with only one doctor, in these instances women were previously either required to attend the clinic repeatedly or attend another NHS services, such as their GP, to obtain the first signature for her HS1A form. However, telemedicine has allowed the sourcing doctors signatures to happen behind the scenes, creating more capacity for doctors and clinicians, relieving pressure on GPs and creating more time for them to see other patients.

QUESTION FIVE: SAFEGUARDING

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.

Every woman is asked by abortion providers whether they are safe at home. This is a routine part of abortion care, no matter how or where care is provided. For instance, one NHS service in Wales gives women a safe word in their first interaction so they can raise concerns in the event they are not able to find somewhere private to speak.

The existing system of telemedicine, with in-person care where necessary, provides the best options for women who are victim-survivors of sexual violence or domestic abuse - particularly for those for whom leaving home for the length of time needed to attend appointment would be difficult or dangerous because their partner or family is monitoring their behaviour and travel. Telemedicine enables these women to access abortion care without risking their personal safety. Women in difficult circumstances are now more likely to seek regulated care and support in the knowledge that they will not be forced to travel to a clinic to access that help.

Services such as Women on Web, which have previously been contacted by women who were unable to access care as a result of their home circumstances and thus needed to receive (illegal) abortion care at home, report that requests for illicit online abortion medication from Great Britain fell by 88% during the initial months of telemedicine. As a result, vulnerable women are no longer risking life imprisonment by seeking to access care outside the legal, regulated healthcare system.

Abortion providers report that providing care remotely actually led to increases in the number of women disclosing problems at home. BPAS reported that in the first three months of their Pills by Post service, 10% of clients underwent an enhanced safeguarding risk assessment – a 12% increase compared to March 2020. For under-18s treated, there was a 25% increase in the proportion of clients referred to social services or the police compared to the same period in 2019. Clinicians providing abortion services report that telemedicine has made women more willing to disclose

concerns about safety when in the privacy and familiarity of their own surroundings, as opposed to a clinical environment.

Telemedicine is not a barrier to the discussion of safeguarding or domestic abuse concern and abortion services continue to provide in-person care where telephone consultations raise safeguarding concerns such as safety or privacy at home, ability to consent, or wider safety concerns surrounding existing children or statutory concerns such as Female Genital Mutilation.

QUESTION 6: IMPACT ON DIFFERENT GROUPS AND COMMUNITIES

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?

Everyone should be able to access safe, free abortion but with a legal requirement to attend a clinic, that doesn't happen.

AGE

Younger women and girls under 18 are disproportionately likely to lack the ability to travel for care due to a lack of access to private transport, or the money to travel on public transport. During the pandemic there were also sizeable numbers of student-age women living at home with their parents and seeking to conceal their pregnancy and abortion. Telemedical abortion services increase accessibility for this group and enable them to access care whilst retaining their privacy.

DISABILITY

Disabled women may have different access needs which affect their capacity to visit hospitals and clinics in person or mean that they *must* forgo privacy in order to attend appointments or access clinic premises. This applies to women with physical disabilities who may struggle to access scans, but also women with disabilities such as agoraphobia which limit their ability to attend healthcare premises.

Disabled women are less likely to have their own means of transport and may require an escort to attend a clinic. Some women may be unable to travel at all. Without telemedicine, there is a real risk that these women are forced to turn to illegal online options because they cannot access care within the formal healthcare system.

RACE AND RELIGION/BELIEF

Members of all communities in the UK access abortion services, even where their cultural or religious background disagrees with abortion access. These women are disproportionately likely to need to access care privately and without the need to travel due to their living or social arrangements – accessing abortion care without the need to travel is only ultimately available via telemedicine.

Further, religious women report that their experience of anti-abortion protesters outside clinics has a negative impact on their mental health and in some instance and caused severe anxiety.

SEX

1 in 3 women will access abortion care during their life. The legal provisions that allow women to access this care are a fundamental part of women's healthcare and the exercise of women's rights in this country. Abortion should not be subject to unnecessary, politically-driven restrictions which are

not in place for other forms of gender-neutral healthcare. Women have the right to access abortion, and should have the right to access high-quality, evidence-based care.

QUESTION 7: IMPACT ON ECONOMICALLY DISADVANTAGED PEOPLE

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?

In the 20th Century, socio-economic status should not impact a person's ability to access reproductive healthcare, but sadly it does. There are hidden costs to accessing abortion services, some of which are removed by early medical abortion at home.

National abortion statistics show that women in more deprived circumstances are more likely to need to access abortion services. We also know from national statistics that they are:

- Less likely to have access to private transport – meaning they often rely heavily on public transport which may affect the cost, time, and difficulty of attending an in-person appointment.
- More likely to work in jobs with poor benefits or zero-hour contracts where sick pay is minimal or non-existent - which may make it more difficult to get time off work for appointments and to pass the pregnancy in the days subsequent to the appointment
- Less likely to be able to afford childcare – creating another barrier for accessing care, as if a woman cannot afford to pay for childcare whilst she attends an in clinic appointment she is likely to delay, or not access care at all.

Abortion providers report that women on lower incomes may often struggle to access clinics – asking providers to delay appointments until they are next paid so that they can afford travel or childcare. This delays their appointments and increases average gestation – increasing their risk of complications.

Requiring women to attend clinics disproportionately negatively impacts women from disadvantaged backgrounds.

QUESTION 8:

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

Become a permanent measure?	X
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)?	
Other [please provide details]?	

CONTACT

[information redacted]

WOMEN'S HEALTH CROSS-PARTY GROUP MEMBER ORGANISATIONS

- Abortion Rights Cardiff
- Abortion Service Lead, Aneurin Bevan University Health Board
- Abortion Service Lead, Betsi Cadwaladr University Health Board
- Abortion Service Lead, Cardiff And The Vale University Health Board
- Abortion Service Lead, Cwm Taf Morgannwg University Health Board
- Abortion Service Lead, Hywel Dda University Health Board
- Abortion Service Lead, Swansea Bay University Health Board
- British Medical Association
- British Pregnancy Advisory Service
- Community Pharmacy Wales
- Dawn Bowden MS
- Endometriosis UK
- Fair Treatment for The Women Of Wales
- Helen-Mary Jones MS
- Jenny Rathbone MS (chair)
- Mike Hedges MS
- Royal College of Midwives
- Suzy Davies MS
- Women's Equality Network Wales