Future Arrangements for Early Medical Abortion at Home

Consultation Analysis Report

June 2021

Scottish Government
Riaghaltas na h-Alba
gov.scot

Contents

Executive Summary

Introduction

The way early medical abortions are conducted was amended as a result of the COVID-19 pandemic. From the end of March 2020, eligible women were able to take both pills required for an early medical abortion (EMA) in their own homes following a telephone or video consultation with a doctor or nurse, and without the need to first attend a hospital or clinic for an in-person appointment. Both pills could either be collected from a clinic or local pharmacy, or be delivered to the patient. After six months of operating these new early medical abortion at home (EMAH) procedures, the Scottish Government launched a public consultation, seeking views on whether the arrangements should be made permanent, or whether it would be preferable to revert back to the previous arrangements.

In total, 5,537 substantive responses were received and analysed. This included 5,465 responses from individuals and 72 from organisations. Several campaigns were run, largely by pro-life organisations, plus one pro-choice campaign co-ordinated by a few different organisations. The largest campaign was run by Right to Life and generated 2,780 standard responses, accounting for approximately half of all responses.

Key Results

Impact of the Current EMAH Arrangements on Women

Respondents were asked to comment on the impacts of the current EMAH arrangements on safety, accessibility and convenience of service, and waiting times for women.

	All Respondents			Excluding Right to Life Campaign		
	Safety	**Accessibility & Convenience**	**Waiting Times**	**Safety**	**Accessibility & Convenience**	**Waiting Times**
Positive	**21%**	**18%**	**16%**	**43%**	**36%**	**33%**
No Impact	1%	1%	1%	2%	1%	2%
Mixed	2%	4%	4%	5%	8%	7%
Negative	**74%**	**67%**	**64%**	**47%**	**34%**	**27%**
Don't Know	1%	4%	8%	2%	9%	17%
Not Answered	1%	6%	7%	1%	12%	14%
Base	5537	5537	5537	2757	2757	2757

Across all measures, most respondents felt that the impacts were negative, with around two thirds to three quarters of all respondents giving this rating. However, the results were more mixed when the Right to Life standard campaign responses were excluded, with more equal proportions suggesting the EMAH arrangements had a positive or a negative impact across each measure.

Most of the safety concerns centred on, or resulted from, the lack of any in-person appointments. It was felt this could limit/complicate opportunities to:

- Confirm the identity of the patient and that they have a safe home situation to undertake the procedure;
- Assess mental health or emotional issues, and identify any potential medical complications (for example, ectopic pregnancies);
- Identify abuse or coercion generally, or to detect forced abortions;
- Confirm gestational age to establish eligibility for EMA; and
- Assess the patient's understanding of the procedure, their expectations and the risks for potential longer term emotional impacts.

There was also a strong sense that the EMAH approach did not provide the necessary levels of safeguards for the patient's emotional wellbeing, and could leave them isolated, making the procedure more traumatic.

Both the convenience and the reduced waiting times were also felt to have had a negative impact by some. They considered that the ease of access trivialised the procedure, with respondents worried that women may not fully understand/ appreciate the potential trauma and long-term impacts involved. Others were concerned that women may feel more rushed into making the decision and taking the medication, and not given/take the time to seek information on alternative options.

Conversely, those who felt the EMAH arrangements had a positive impact argued that this improved accessibility and reduced waiting times, which in turn allowed the procedure to take place at an earlier gestation. It was highlighted that earlier intervention reduced the risk of complications and made it safer for women. Reduced waiting times were also felt to have a positive impact on women's mental health as it reduced anxiety over that period, while not having to attend a clinic/hospital meant that women could avoid any pro-life campaigners who were outside clinics. Overall, it was felt that being able to conduct the entire procedure from home reduced the anxiety, stress, stigma, and trauma experienced by women when accessing abortion services.

It was also suggested that the EMAH arrangements often facilitated safer access to services for women in abusive/coercive relationships by making the process more discrete, private and confidential. Some also indicated that women may be more likely to disclose abuse from the comfort of their own home compared to the formal setting of a clinic or hospital.

Accessibility barriers, both financial and physical, were also considered to have been removed by EMAH arrangements, including costs and access to suitable transport to/from appointments, the need for childcare, the need to take time off work, etc.

Impact of the Current EMAH Arrangements on Service Providers

The consultation also asked for feedback on the impacts of the EMAH arrangements on those involved in delivering services. Again, two thirds (66%) of all respondents felt that the impacts would be negative, with the proportions of those identifying positive (30%) and negative (31%) impacts becoming more equal when the Right to Life standard campaign responses were removed.

The main suggested negative impact for service providers was a depleted relationship between the doctor or nurse and their patient due to the use of teleconsultations. It was felt that it would be less clear to health professionals if a patient was fully informed before making their decision, or if they were being coerced into an abortion. Further, it was suggested that the lack of personal consultation would hinder NHS staff's ability to conduct informed health and risk assessments. It was also suggested that the current arrangements may not lend themselves to good patient care, or protection of workers' mental health (linked to the risk of being held accountable for patient safety and any misuse), thus eroding professional standards of care.

Those who perceived there would be a positive impact on service providers focused primarily on flexibility and efficiency. They suggested the EMAH made services more accessible, responsive and efficient, and thus enabled service providers to make time savings while still offering quality care to women seeking an abortion. The telemedicine approach was seen as less time intensive, therefore allowing practitioners to allocate more time to caring for patients with greater medical or support needs. Further, it was noted that current EMAH arrangements enabled the procedure to take place at lower gestation, resulting in fewer complications requiring attention from medical providers, again freeing up time to be spent with other patients.

Risks of the Current EMAH Arrangements and Possible Mitigation

Respondents outlined a long list of perceived risks associated with the current arrangements. Respondents felt there was a risk of serious complications arising as a result of the procedure and the doctor's or nurse's limited ability to assess and verify eligibility of the patient, use of the medication 'at home', and any signs of coercion. It was also suggested that EMAH would result in women being provided with less information around the risks or alternative options, as well as a reduction in the provision of/access to psychological support.

The main mitigation measure suggested by respondents was to offer patients a choice of in-person appointments or 'at home' consultation (although in-person appointments are already an option where the patient chooses it). It was also suggested that services should provide routine follow-up contact with patients for

both medical and emotional purposes, that counselling should be offered pre- and post-procedure, and that a 'cooling off' period should be built into the approach.

Several other mitigation measures were also suggested by respondents, but were noted by others to already be in place. This included training on how to identify abuse and coercion; the provision of a 24/7 helpline; clear instructions for medication use, what to expect, and when to seek further assistance; and clear and robust questioning to gather the necessary information during a teleconsultation.

Impact Assessments

The consultation asked a series of questions which sought feedback on the impacts of the EMAH arrangements on equality groups, people in different socio-economic circumstances, and for women living in island and rural locations.

In relation to equality groups, impacts were noted for pregnancy and maternity, disability, religion or belief, minority ethnic groups, age, gender reassignment and sexual orientation, and marriage and civil partnership. Across most groups, those who identified positive impacts tended to feel that access had been improved, either by providing a more private and discrete service or due to the removal of financial and physical barriers, thus providing greater equality in access to healthcare. This argument was repeated for socio-economic groups and those living in island or rural locations. They also felt that EMAH was more patient-centred, and that patients had been empowered and allowed greater control over their treatment. Improvements in service were felt to be important for these highlighted groups as historically they had experienced disempowerment and exclusion.

For those who felt the impacts were negative, they reiterated the main risks of the procedure for the patient and suggested that this could create inequality in healthcare because women were not being provided necessary protection, medical attention or emotional support. They also felt that the risks were particularly acute for those living in island and rural locations where emergency medical support would be harder to access should they encounter complications. Respondents also suggested that the current arrangements could introduce communication and technological barriers for some patients (including those in particular equality and socio-economic groups), and leave some groups at greater risk of coercion, abuse, or forced abortion going undetected. Specific to religion and belief, some were concerned that staff who may be conscientious objectors could become involved in the distribution of the abortion medication. Further, in relation to socio-economic issues, some respondents worried that poverty could make women feel that an abortion was the only option and that the speed and ease of access via EMAH could result decisions being taken for financial reasons without sufficient consideration.

Future Arrangements

The consultation document sought views on respondents' preference for EMA provision once COVID-19 was no longer a significant risk. Overall, 61% of all respondents indicated they would prefer a return to the previous arrangements.

However, when the Right to Life standard campaign responses were excluded, 42% would prefer 'other' arrangements to be introduced, 34% would prefer the current EMAH arrangements to be retained, and 21% would prefer the previous arrangement to be reinstated.

Other arrangements that were suggested included offering a blended approach of both 'at home' and in-person appointments depending upon risk levels and patient preferences, moving back to a more clinic-based setting, providing greater support/ information, or removing EMA or abortion provision entirely.

Other Comments

A number of other comments were made throughout the consultation responses which did not directly answer the set questions. These were generally related to compliance with the Abortion Act 1967, issues with abortion/EMA generally (rather than specifically linked to the current EMAH arrangements), and perceived gaps in the consultation.

Conclusion

While the number of respondents who were against EMAH was significantly higher than those in support of it, it should be noted that this was heavily impacted by the large numbers who had either submitted a campaign response or had been influenced by one of several campaigns organised by pro-life or faith groups. Further, a sizeable proportion of those against EMAH were also against any and all forms of abortion, and as a result, some of the concerns raised were applicable to abortion generally, rather than being specifically related to EMAH.

Key areas of concern were discussed in several areas across consultation responses, including perceived reductions in safeguards with regards to both the administration of the medication and the physical and psychological safety of the patient. Conversely, those who were largely supportive of the EMAH approach argued that it was safe, and provided a more accessible patient-centred service where women were afforded greater autonomy over their bodies and healthcare.

While it appears that there was a clear preference for the previous arrangements to be reinstated, this view was driven largely by the Right to Life campaign - and indeed most of these respondents suggested that they would prefer both pills to be taken in a clinic (so would not in fact represent a return to previous arrangements). The preferences for future provision as identified by other respondents, however, were mixed, but it was important that choice was provided, and therefore, it was felt that both in-person and at home methods should continue to be offered.

Introduction

Background to the Research

In Scotland, the majority (over 80%) of women opting for an abortion (also known as a termination of pregnancy) have an early medical abortion (EMA), i.e. an abortion in the first twelve weeks of pregnancy where the woman takes two sets of pills (mifepristone and misoprostol) to end the pregnancy (as opposed to a surgical abortion). Until late 2017, women were required to attend a hospital clinic on two separate occasions to take the two sets of pills. Since the end of October 2017, many women have been able to take misoprostol at home, but still had to attend a hospital clinic to take the first medication (i.e. mifepristone).

As a result of the COVID-19 pandemic, however, the way that EMAs were conducted was changed. In March 2020, the Scottish Government put in place an approval to allow eligible women to take both pills required for an EMA in their own homes following a telephone or video consultation with a doctor or nurse, and without the need to first attend a hospital or clinic for an in-person appointment. Both pills could either be collected from a clinic or sent to the patient via courier/post. This method of early medical abortion from home (EMAH) aimed to allow access to abortion services without delays, while minimising the risk of COVID-19 transmission.

After six months of operating these new EMAH procedures, the Scottish Government conducted a public consultation seeking views on whether the arrangements should be made permanent, or whether it would be preferable to revert back to the previous arrangements. The consultation ran from 30th September 2020 to 5th January 2021. It sought feedback on the impacts and risks associated with the current arrangements, as well as potential impacts on certain groups of continuing these arrangements (i.e. equality groups, socio-economic equality and for those in rural and island locations), and views on what the future approach should be.

Views were sought from both individuals and organisations via the Scottish Government's online consultation tool, Citizen Space. Due to the COVID-19 restrictions no face-to-face consultation activities or events were possible.

Respondent Numbers and Profile

A total of 5,607 responses were received, however, two of these were removed from the analysis for being invalid (one was blank and the other gave a response at Q1 only which was not relevant to the consultation questions). In addition, 68 sets of duplicate responses were identified (i.e. where the same individual had submitted two separate responses with the same content). These were reconciled into a single response for each while ensuring there was no loss of content.

As such, **the final number of substantive responses included in the analysis was 5,537**. This includes 5,465 responses from individuals and 72 from organisations.

More than half of the included responses (3,165) were submitted via email, although the majority of these (3,110) were generated by an organised campaign (discussed in more detail below). A further 2,329 responses were submitted via Citizen Space and 43 responses were received by post.

While respondents did not have to say whether they had any experience of abortion services, several did self-identify themselves as such within their responses. Overall, 46 respondents indicated that they had either had an abortion at some point in the past (n=34) or had experience of closely supporting someone who had had an abortion (n=12).

Most responses followed the standard format, although several were received which did not address the specific consultation questions and/or which provided views in relation to abortions more generally. All responses were considered by the analysis, with a synopsis of additional issues discussed included in the 'Other Comments' chapter below.

Campaign Responses

Several organisations (mostly pro-life) ran campaigns encouraging people to respond to the consultation. While some organisations may have encouraged their members/service users to participate, seven campaigns were identified where respondents followed some form of standardised response. Both standard responses (i.e. where answers were identical to the original materials) and non-standard responses (i.e. where responses followed the campaign text in places but not throughout and/or included additional information) were identified, as follows:

Campaign Responses

Campaign	Standard Responses	Non-Standard Responses
Right to Life	2780	363
Society for the Protection of Unborn Children (SPUC)	8	93
CARE: Short Version	1	16
CARE: Long Version	0	6
Christian Institute	0	24
Catholic Parliamentary Office	0	10
Engender, British Pregnancy Advisory Service (BPAS) and Amnesty International	0	40

Although many of the individual campaign responses were similar and made the same substantive points, they were classified as non-standard if the content of the response closely followed the original campaign material despite the phrasing being different, or if text had been taken verbatim but was supplemented with additional information.

Given the scale and level of detail provided in the Right to Life campaign, and the large numbers adhering to the standard response format in particular (i.e. accounting for 50% of all responses), dedicated coverage of this has been provided in Appendix A. The views provided by these respondents are also represented throughout the main body of the report for fullness, and in many cases were consistent with the views expressed by non-campaign respondents. When interpreting the results overall, however, it should be borne in mind that findings will be skewed by the large numbers of standard campaign respondents who answered each question.

As the other campaigns (and non-standard Right to Life campaign responses) were smaller in scale, with individuals often offering unique responses, a dedicated synopsis has not been included for each. Those who provided non-standard responses often focused on fewer points than the full campaign, or provided additional information, discussed additional topics, or deviated from the campaign response entirely at individual questions. This means that a synopsis of these campaigns would not fully represent the individual contributions that were made. In addition, the issues discussed by the campaign respondents were typically highlighted in other, non-campaign based responses, therefore, providing a synopsis for each campaign would increase repetition within the report and would perhaps overstate the various points raised.

Organisation Responses

Although organisations were not required to identify which sector they represented within the consultation response, most provided their organisation name. This allowed for organisations to be categorised into sectors during the data cleaning phase. The number of organisations per sector are outlined below.

Organisational Sectors

	Number	Percent
Pro-Life and/or Faith Groups	31	43%
Professional Bodies (including Royal Colleges, Professional Organisations of Healthcare Providers, Universities/Academic Bodies, Trade Unions and Voluntary Sector)	13	18%
Healthcare Providers (including NHS, Third Sector and Private)	12	17%
Women's or Abortion Support Groups	12	17%
Other	3	4%
Not Specified	1	1%
Total	72	100%

Analytical Approach

The analysis of the responses was carried out by Wellside Research. Wellside Research was contracted to prepare this report on behalf of the Scottish Government, but carried out the analysis independently.

All responses were logged into a Microsoft Excel database and screened to identify any campaign, blank, non-valid (i.e. where responses were not relevant to the current consultation), or duplicate responses. These responses were categorised, removed or cleaned as detailed above. Remaining feedback was then analysed, and is presented under the appropriate sections below.

Closed question responses were quantified (in Excel) and the number of respondents who selected each response option reported.

Qualitative comments given at each question were read in their entirety and manually examined to identify the range of themes and issues discussed. Microsoft Excel was used to record and quantify responses (where possible) as positive, negative and mixed at some questions (i.e. Q4, Q5 and Q6). Analysis was also conducted to identify any differences in views between respondent groups (i.e. between individuals and organisations, or between organisational sectors). Recurring themes which emerged throughout the consultation were recorded, and verbatim quotes were extracted in some cases to illustrate results. Only extracts where the respondent consented for their response to be published were used.

Caveats and Reporting Conventions

Findings are presented as they relate to each question in the consultation. Where individual respondents offered views at the open questions that differed from those submitted by organisations, or where views differed between the different organisational sectors, this was identified and outlined in the narrative of the report.

It should be noted, however, that there was substantial consistency between the views of individuals and organisations, with responses split typically by whether respondents were supportive or not of the EMAH approach. For example, pro-life and faith organisations views were largely consistent with those individuals who were against the current arrangements (or abortion more generally), while healthcare providers were largely supportive. Within organisational categories there were also splits in opinion, again based on the nature of their work and the experiences of their client base. For example, women's and abortion support services were split between those in favour and those against, depending on whether their role facilitated access to choices for women in healthcare or those who tended to support women who had had traumatic experiences as a result of the abortion process.

Some respondents opted not to answer closed questions, but did offer open-ended responses to the same question meaning that there was not always a direct corelation between the number of people who supported/did not support a particular statement and the number of people who gave a qualifying comment. For

fullness, all responses were included in the analysis, even where the closed component of the question had not been answered.

There was also considerable overlap in the issues discussed by respondents selecting different closed response options within questions. For example, those selecting there were no impacts, mixed impacts or stated they did not know, often provided qualitative comments which focused on similar issues to those who had felt the impacts were positive or negative. In order to avoid repetition, the issues raised in the qualitative comments have been summarised under the relevant positive or negative headings, irrespective of the closed option selected at each question.

In addition to the campaign responses that were identified, there was also evidence of respondents co-ordinating or sharing responses more generally. This was evident between organisations who cited information or arguments provided by others or provided the same information in the same way as part of their answers, and individuals who appeared to have consulted organisations' responses to inform their own.

The purpose of this report was to detail the various issues and topics identified and discussed by respondents. As such, the views presented represent those of the respondents and not the authors or the Scottish Government. It should also be noted that inaccuracies in the information presented by respondents may have been retained. While every effort has been made to fact-check such information and caveats have been included where appropriate, this has been retained as it represents the views and opinions of those respondents. Similarly, while terminology may not be medically accurate in places, the report largely retains the terms and wordings commonly used by respondents throughout.

It should be noted that, consistent with the consultation paper, this report refers throughout to 'women' accessing abortion, but this is intended to refer to any patient who may seek an abortion, regardless of their age or gender identity. It is understood that some trans-men and non-binary people could also require access to abortion services.

Further, the term EMAH (early medical abortion at home) has been used throughout to refer to the current arrangements in place for early medical abortions, i.e. for all aspects of the service to be accessible from home.

Many respondents referenced external sources to support their responses. The content of these external resources was not analysed here, but a full list of these references was provided separately to the Scottish Government for consideration.

The findings here reflect only the views of those who chose to respond to this consultation. It should be noted that respondents to a consultation are a self-selecting group. Therefore the findings should not be considered as representative of the views of the wider population.

Impact of the Current Arrangements

The consultation document asked a series of questions to illicit perceptions and feedback of the impact of the current arrangements, i.e. to allow eligible women to take both pills at home as a result of the COVID-19 restrictions. This included:

- Q1. What impact do you think that the current arrangements for early medical abortion at home (put in place due to COVID-19), have had on women accessing abortion services? Please answer with regards to the following criteria:

  a). Safety;
  b). Accessibility and convenience of services; and
  c). Waiting times.

- Q2. What impact do you think that the current arrangements for early medical abortion at home (put in place due to COVID-19), have had for those involved in delivering abortion services? (For example, this could include impacts on workforce flexibility and service efficiency.)

Impact on Women's Safety

Q1a. What impact do you think that the current arrangements for early medical abortion at home (put in place due to COVID-19), have had on women accessing abortion services? Please answer with regards to the following criteria - Safety?

Impact of the current arrangements on women's safety

	All Respondents		Excluding Right to Life Campaign	
	Number	**Percent**	**Number**	**Percent**
Positive Impact	1190	21%	1190	43%
No Impact	50	1%	50	2%
The Impacts are Mixed	130	2%	130	5%
Negative Impact	4,076[1]	74%	1296	47%
I Don't Know	57	1%	57	2%
Not Answered	34	1%	34	1%
Total	5537	100%	2757	100%

[1] It should be noted that the Right to Life standard campaign responses received stated 'Positive Impact' at this question, however, all qualitative comments discussed negative impacts. Therefore, it was assumed that the 'positive impact' rating was an error on the campaign template and so it was amended within this report to ensure the intentions of the campaign are accurately represented.

When considering responses from all respondents, 74% felt the impact of the current arrangements on women's safety was negative compared to 21% who felt they were positive. The proportions were much more balanced however, when the Right to Life standard campaign responses were excluded from the analysis, with 47% suggesting the impact was negative compared to 43% who felt they had a positive impact.

Respondents were also offered the opportunity to provide qualifying comments to support their response to the closed element of the question, with 4,408 providing further detail. Of these, 2,780 were Right to Life standard campaign responses who provided identical answers.

Positive Impacts

For those who felt the current arrangements for EMAH provided positive impacts for women's safety, the main reason cited was the timely access to medical intervention. It was noted that, without the delays of waiting for appointments, women were able to present and access the treatment quicker. As such, this was considered superior to the previous arrangements as it allowed termination earlier in the pregnancy, which results in lower risks to the woman and less chance of complications as a result of the procedure. Indeed, several organisations cited evidence that showed the average gestation period at which EMAs were carried out had reduced as a result of EMAH:

> "Having had a service with long wait times for the Termination of Pregnancy Service pre Covid-19, this change has been positive as women can access the service speedily and this means that they can have treatment at an earlier gestation which in turn reduces the risks associated with a later gestation termination of pregnancy, this provides a safer set of circumstances." (Individual)

Many felt that the current arrangements provided greater comfort, safety and convenience as women were allowed to make the decision, undertake the consultation and take the pills all in their own home. This was considered to be less daunting and stressful than visiting a clinic. It was also seen to provide women with control and choice over who they had to support them during the process, as well as when to begin the medication. It was proposed that these amendments in practice provided more control over when and where they would pass their pregnancy which could improve both physical and mental safety:

> "This gives women more choice of when and where to have the procedure. Women are able to make the choice of when and where they feel most comfortable which is a positive thing for their physical and mental health." (Individual)

Further, it was suggested that women will experience less judgement, stress and anxiety by being able to deal with the whole situation from home, and in particular allow them to avoid the "harassment" they may face from pro-life advocates/protesters when attending a clinic. As such, it was felt that the current arrangements better protected women's mental health. Individuals with experience

of the previous arrangements suggested these were stigmatising and traumatic, with one indicating that the anxiety of attending a clinic had delayed them seeking the procedure. These respondents felt that the current arrangements were a significant improvement.

It was believed that the current arrangements had helped to keep women, their families/households and healthcare staff safe during the COVID-19 pandemic. As women didn't need to travel or attend a hospital or clinic it was assumed this supressed the transmission of the virus. This was seen as particularly helpful for women who had needed to shield (or had members of their household who were vulnerable or shielding) during the pandemic.

Both individuals and organisations felt that the EMAH arrangements improved safety for women in abusive relationships by making the process more discrete, private and confidential. This discretion was considered to be particularly beneficial for those in smaller/rural communities. In particular, it was noted that travelling to a clinic may be difficult for women with coercive and controlling partners or those who have to account for time spent out of the house/away from work and for travel expenses. As a result, it was suggested that the current arrangements allow women in such circumstances more control over their situation:

> "With the spike in domestic abuse during lockdown, women may find this is the safest and less traumatic than being coerced into carrying an unwanted or unintended pregnancy and be able to bypass their abuser to access the safe medical procedure they require." (Individual)

Several respondents suggested that the current approach may also encourage the disclosure of abuse to a greater extent, with respondents citing evidence from providers in England which indicated that women were more likely to disclose abuse when it can be discussed outside of a clinic setting. Organisations highlighted that staff were trained to assess vulnerability during teleconsultation, with a few noting that identification of abuse by such service providers had risen during the COVID-19 lockdown demonstrating that this provided a useful support for women.

Several felt that this was a safe procedure, with a few noting it was physiologically comparable with early medical treatment for miscarriage, and so felt there was no reason it could not take place at home. It was considered that appropriate safety nets were in place to ensure a safe service. In particular, teleconsultation, the provision of instructions and advice, and contact numbers for advice or emergency situations were seen as appropriate, supportive measures of the current approach. Several noted that there was sufficient evidence to reassure respondents that the current approach was safe, and/or that there had been no increases in the safety risks or safeguarding concerns introduced by the current approach compared to in-person consultations. Evidence from the situation in England and Wales was cited, as well as data and recommendations from the World Health Organization (WHO).

A few noted that, for women who either could not or would not access a clinic for the treatment, the current arrangements were safer than trying to access abortion

pills via unregulated channels (such as over the internet) or attempting 'homemade' abortion techniques. Organisations in particular, noted that since the introduction of the current arrangements the rate of women seeking abortion medication outside the formal healthcare setting had reduced significantly. These respondents highlighted that those previously too vulnerable to attend in-person had been able to access the necessary care and that a larger number of women were potentially benefiting from the wider care provided by regulated providers, e.g. safeguarding, counselling and contraceptive services.

A few who felt the impacts were positive overall, however, suggested that there should perhaps be increased follow-up care/consultation available/provided.

No Impact

Those who felt that making EMAH permanent would have no impact on women's safety generally highlighted that there had been no significant change in the statistics. They argued that complications would be a risk regardless of the arrangements and setting, but noted that the data showed these risks, or instances of these risks arising, had not increased since the introduction of the current arrangements.

Negative Impacts

With regards to the specific proposals, many of the main concerns focused on the lack of an in-person consultation. It was suggested that teleconsultations would not be as effective, and that various issues could not be confirmed or potential problems could be missed if the doctor or nurse does not see the woman in person. Potential issues identified included:

- assessing/confirming the patient's mental condition;
- identifying patients who are being abused or coerced, either in relation to the pregnancy or abortion, or more generally;
- assessing the true safety situation of the patient or where the pills will be taken;
- confirming the identity of the patient and whether the pills are for them or will be passed on to someone else;
- confirming the eligibility of the patient, including whether they are pregnant at all and if so, to accurately determine what gestational age they are at;
- assessing/identifying any underlying health concern and potential medical complications;
- assessing/identifying any trauma; and
- assessing the patient's understanding of the procedure, what to expect and the potential longer term emotional effects:

> "I feel that consultation over a screen is by no means as effective as a face-to-face, where body language, facial expression and tone can be easier read. This allows for the healthcare practitioner to better deem whether the person may be being coerced into an abortion, be

> mentally stable enough to go through with an abortion and whether they really understand the possible side effects of these drugs and the weight of the decision to abort." (Individual)

A significant issue for respondents was that the teleconsultation was unlikely to be able to identify coercion and abuse, both in terms of those being victims of this generally or having an unwanted pregnancy due to sexual abuse, and to identify those women being coerced into an abortion. It was suggested that, while this risk had been identified in the consultation paper, no solutions or safeguards had been presented to mitigate this. It was also felt that the current arrangements made it too easy for people to obtain pills for others and/or for them to be obtained and given to women against their will or without their knowledge (e.g. in the case of abusive relationships, controlling family situations, child abuse or people traffickers). Further, it was suggested that those perpetrating abuse may withhold access to emergency medical support after the pills had been taken:

> "If arranged by phone and drugs delivered home there is also the risk of a controlling partner arranging abortion on his/her partner without their knowledge/agreement and administering drugs via food." (Individual)

The lack of any in-person examination or need for medical supervision when taking the medication was also felt to increase the risk that the pills could be taken beyond the appropriate gestational period. This included concerns that women could be obtaining and taking the pills beyond the recommended or legal timescale, either by miscalculation or deliberately giving false information. Other concerns were that they could obtain the pills but not take them until much later, or that they might misunderstand or be unable to follow the instructions for taking the pills. It was noted that this carried risks to the physical health of the women as the risk of complications (such as haemorrhaging and incomplete abortion) increases with gestation period, which could require hospitalisation, surgery and other serious medical interventions as a consequence. Some respondents highlighted that there was evidence of abortion pills being taken later than advised in England[2], and so felt it would be inevitable that this would also happen in Scotland:

> "The self-administration of abortion pills removes any control over who takes the pills, where they are taken, whether they are taken, when in the pregnancy they are taken, and in the case of underage patients, whether an adult is present. It is not clear how healthcare professional can ensure the pills are taken by the individual they are provided to and within the appropriate time frame." (Organisation, Pro-Life or Faith Group)

Many respondents also cited a number of adverse incidents in England following the introduction of the temporary approval in England in March 2020.

[2] The current temporary approval in England allows eligible women to take both pills for early medical abortion up to 10 weeks gestation at home, following a telephone or e-consultation with a clinician.

It was also felt that EMAH reduced the safeguards for women's emotional wellbeing. It was suggested that they would feel isolated, that there was insufficient time or processes to ensure they had fully considered and discussed their choice, and that they were being left to go through with abortions by themselves without adequate or ongoing moral or medical support and advice. It was suggested this reduced access to support could be particularly acute for girls and young women who were perhaps trying to keep the pregnancy and abortion a secret from family and friends. Many felt it could be emotionally traumatic, and so there were implications for their longer-term mental health, with the risk of suicide being noted in extreme cases. A few respondents were also concerned that the lack of input from a clinical practitioner at the point of taking the pill(s) would leave women feeling more responsible for the abortion, resulting in greater emotional turmoil, with a few also querying the legality of this and whether the current arrangements meant that women were breaking the law:

> "…women may be committing an offence under the Abortion Act 1967 if they are now taking both the early abortion drugs, mifepristone and then misoprostol at home. Indeed, it is the woman wanting an abortion who is basically terminating the pregnancy and not a registered medical practitioner as required by Section 1(1) of the Abortion Act 1967." (Organisation, Other)

It was felt that a greater level of moral support was required and potential for counselling following the procedure. It was also noted by several respondents that greater efforts should be made to signpost and discuss alternative options ahead of the procedure to ensure this truly is the right decision in each case - it was felt this could help to avoid some of the longer-term trauma and mental health impacts.

It was pointed out that the consultation document noted instances of risks to women's health, and referred to instances of significant complications in Scotland without providing details of these. As such, it was felt there was too little evidence to suggest these current arrangements were safe or improved patient safety.

Many felt that the lack of a scan would increase the risk of ectopic pregnancies not being detected and for pregnancies to be further along than estimated or disclosed by the woman via the teleconsultation. It should be noted however that several organisations who felt the impacts were positive stressed that there was no need for a scan or ultrasound in all cases and that there was no greater risk of ectopic pregnancies being missed.

Finally, some respondents were against all forms of medical abortions and/or abortions more generally, with qualitative comments focusing on the rights of the fetus or on the grounds of faith/religion. Others were against the 'at home' nature of the procedure and felt that abortions should only take place under medical supervision within a clinic or hospital setting. Where reasons were given, these often mirrored those outlined above or focused on concerns which would apply equally to the previous EMA arrangements and so were not generated by the move to the current arrangements (e.g. being alone during the process, experiencing complications, etc.). These concerns are outlined in the 'Other Comments' chapter.

Impact on Accessibility and Convenience of Services

Q1b. What impact do you think that the current arrangements for early medical abortion at home (put in place due to COVID-19), have had on women accessing abortion services? Please answer with regards to the following criteria - Accessibility and Convenience of Services?

Impact of the current arrangements on accessibility and convenience of services

	All Respondents		Excluding Right to Life Campaign	
	Number	Percent	Number	Percent
Positive Impact	987	18%	987	36%
No Impact	28	1%	28	1%
The Impacts are Mixed	216	4%	216	8%
Negative Impact	3733	67%	953	34%
I Don't Know	239	4%	239	9%
Not Answered	334	6%	334	12%
Total	5537	100%	2757	100%

Just over two thirds (67%) of all respondents felt that the current arrangements had a negative impact on the accessibility and convenience of services. However, this was largely driven by the Right to Life standard campaigns, as the proportions who felt the arrangements had a positive (36%) or negative (34%) impact were similar when these responses were excluded from the analysis.

Again, respondents were provided with the opportunity to provide further details, with 3,869 respondents providing a qualitative answer (although it should be noted that some respondents also discussed accessibility and convenience in their response to Q1a - these responses have been included in the analysis below).

Positive Impacts

Those who felt that the current EMAH arrangements provided positive impacts in relation to the accessibility and convenience of services typically considered that it was easy and quick to access, as well as more convenient for women. This was seen as important during the COVID-19 pandemic in order to reduce the risk of catching the virus while ensuring the service remained available and accessible. Going forward, however, respondents felt that the current arrangements had improved access generally, as well as for particular categories of women, including those in rural areas (where long travel times and potentially overnight stays may be needed for each appointment), those with low-incomes or living in poverty, disabled women (who may find it difficult to travel or access the services), those who work, those who have childcare or other caring responsibilities, and those without access

to private transport. In particular, the EMAH approach was considered to have removed both financial and accessibility barriers for women:

> "All citizens do not experience equal access to healthcare. Some, particularly people from deprived or difficult personal circumstances, experience significant barriers to accessing healthcare, be that due to the inability to afford or organise travel, insufficient time to travel or even fears about having to account for time away from the home." (Organisation, Healthcare Provider)

Other comments made in relation to improved accessibility and convenience often mirrored or were linked to improvements discussed above about safety, with one often impacting the other. For example, it was felt that EMAH provided improved access to the procedure for women experiencing abuse who may not be able to attend a clinic in person or who would find it difficult to account for their time or travel. Similarly, it was again suggested that the ability to take both pills at home allowed women to control the timing of the procedure, to ensure it can be conducted when they are safest, and when their schedule and other responsibilities and commitments best allows for this:

> "…they [women] have the flexibility to take their treatment at a time that suits them (e.g. over the weekend) and so minimise the disruption to their lives (e.g. jobs, childcare)." (Individual)

Again, some respondents argued that they felt the service was more accessible as women would not be put off going to a clinic and passing pro-life campaigners/protestors. Several highlighted that women can feel a sense of shame and can be reluctant to attend a clinic where they may be seen, whereas the current arrangements facilitated more discrete and private access:

> "There is still a lot of shame associated with pregnancy termination. I believe not being scared of being seen or noticed in these places may allow women to really take this decision on their own terms." (Individual)

Several respondents cited research and customer surveys which showed that women who had experienced the current arrangements were happy with the approach, service, accessibility, etc. and noted that a systematic review of evidence by NICE had suggested telemedicine as a way of increasing accessibility of abortion services, especially for vulnerable groups. The perceived improvements to accessibility and convenience were also said to have benefits in reducing the number of women seeking access to abortion pills via unregulated methods (e.g. over the internet).

Despite their support for EMAH, several respondents (particularly, but not exclusively, organisations) did feel that there should be options available, with in-person and at-clinic services maintained for those who would prefer or need these. As such, they suggested that telemedicine approaches should be integrated into the in-person EMA service rather than fully replace the in-person component.

Negative Impact

While many respondents indicated that they felt the current arrangements had improved accessibility and convenience EMA, many felt this was not a positive impact.

Many believed that the ease of access and convenience of the current system had trivialised the practice. Some were concerned that women would not realise that a medical abortion was a major and traumatic procedure, and that they would not be given the full details of the levels of pain they might experience, possible complications, emotional trauma, and possible longer-term physical and emotional risks. Others felt that terminating a pregnancy needed to be given much more weight and gravitas than the current arrangements were considered to bestow:

> "My concern is that by making this too easily accessible to a point where the person does not even have to leave the house, that the decision to go ahead with the procedure may be made rashly, with not enough thought or counselling." (Individual)

The speed and ease of obtaining the pills resulted in a few respondents being worried that this could be used as a form of contraception/birth control. With subsequent fears highlighted over possible increases in sexually transmitted diseases due to a lack of other precautions being taken.

There were also concerns that access to the pills was too quick and easy, and so women could make a rushed decision (which they may later regret), would not have time to fully explore or consider their options, or would not have had access to any support or advice from other services/supporters. A few respondents suggested that some women may make a different decision if they could access support and counselling ahead of taking the pills. Concerns were also raised over whether women could really be considered as providing informed consent via teleconsultation. They felt that a lot of information would be provided which the woman may not be able to fully comprehend via a teleconsultation:

> "Accessibility at home means women may not be fully informed about the procedure and what impact it may have on them." (Individual)

Several suggested that EMAH had created barriers for some women. In particular, the deaf community, those not proficient in English, those experiencing homelessness, those with mental health issues, and some disabled people were mentioned specifically as being less likely to be able to use or fully engage with the online technology or teleconsultation process. It should be noted, however, that the Scottish Abortion Care Providers (SACP) guidelines already state that many of the women in these groups should be seen in person, for example if they are not able to fully understand the information given or if they cannot comply with the 'ordinarily resident' requirement.

Again, several highlighted that the ease of which pills could be obtained left the system open to abuse and misuse. It was felt that the current arrangements were not robust enough to verify the identity of the applicant and true gestation. In

addition, the convenience of the arrangements were a concern in relation to perpetrating and covering up domestic abuse, violence and coercion:

> “It will be very convenient for those who abuse women for their own gain to force her to abort her child against her wishes, because now she doesn't even need to come to a clinic to see anyone. It would be very difficult for her to call for help whilst on a virtual medical appointment if her abuser is there also.” (Individual)

Many argued that convenience was not a key priority for such a procedure, but that other features should be paramount, such as safety, ensuring the woman is provided the appropriate and necessary medical and emotional care, being provided with all relevant information, having the opportunity to explore all options, and receiving the necessary support and ongoing counselling where required. Several respondents noted that polling had suggested that women wanted more safeguards, not fewer. It was felt that the increase in accessibility and convenience had come at the cost of quality and safety, with some highlighting that women would be left in unsafe situations if they experienced complications. Respondents suggested that the medical and psychological care that they considered should be provided with such a procedure had become less accessible under the current arrangements. This perceived decrease in accessibility was identified to be due to the lack of in-person contact ahead of the procedure and the risk that women would be reluctant to seek follow-up support:

> “Services should be accessible but to say that abortions should be convenient is total disregard to the emotional, physical and mental turmoil which would be experienced by any woman.” (Individual)

> “Although the abortions themselves are more accessible the pastoral/medical care of health professionals is not.” (Individual)

Several felt that continuing with EMAH after the COVID-19 restrictions had been lifted was simply a cost saving exercise which would put women at risk. A few others worried that permanently adopting the current arrangements would eventually lead to less in-person provision being available as services diminished in response to reduced demand.

Impact on Waiting Times

Q1c. What impact do you think that the current arrangements for early medical abortion at home (put in place due to COVID-19), have had on women accessing abortion services? Please answer with regards to the following criteria - Waiting Times?

Impact of the current arrangements on waiting times

	All Respondents		Excluding Right to Life Campaign	
	Number	Percent	Number	Percent
Positive Impact	905	16%	905	33%
No Impact	58	1%	58	2%
The Impacts are Mixed	203	4%	203	7%
Negative Impact	3522	64%	742	27%
I Don't Know	475	8%	475	17%
Not Answered	374	7%	374	14%
Total	5537	100%	2757	100%

Just under two thirds (64%) of all respondents felt that the current arrangements had had a negative impact on waiting times. However, when the Right to Life standard campaign responses were excluded from the analysis, one third (33%) felt they had a positive impact on waiting times compared to 27% who felt the impacts were negative.

Respondents were asked to provide further details to support their choice, with 3,673 providing qualitative comments.

Positive Impact

Specific elements of EMAH which were considered to impact positively on waiting times and speed up the process included:

- Self-referral by the woman herself was faster than requiring a referral from a GP (it should be noted, however, that the majority of women were already self-referring directly to abortion services prior to the pandemic);
- Teleconsultations were seen as quicker to arrange than face-to-face appointments;
- Not all women needed to wait for a scan;

> "Waiting times have been dramatically reduced as clinical capacity was previously limited by availability of scanning. Allowing medical staff to triage women based on symptoms and history for a scan if they needed one has meant resources are used more appropriately,

rather than forcing all women to have a scan, which is unnecessary in most cases and can cause distress to women." (Individual)

- Women not having to travel to appointments.

Some respondents cited examples of reduced waiting times associated with the current arrangements (both from published data and personal experience). For example, it was suggested that teleconsultations could be undertaken the same day or within days of the appointment being made, with access to the pills very quickly afterwards (with a few indicating this could be as quick as the same or next day following the teleconsultation). Some considered this to be a significant benefit as it reduced/removed the anxiety of waiting for appointments and barriers of attending in-person appointments. It was also felt to benefit those who found out later that they were pregnant, or made the decision to terminate later into the pregnancy and so there was little time left to access the procedure within the recommended gestation period - in such cases, time was of the essence.

Another positive impact identified was that women would not have to spend time waiting in clinics for their appointments. Removal of in-clinic waiting was considered less time consuming for women and also increased privacy as they could avoid spending time in waiting rooms (which was noted as being a stressful and unpleasant environment for women seeking abortions). Even where scans were required, it was suggested that the appointments and waiting times for these would be shorter as a result of the lower demand on this aspect of the service.

Similarly, several respondents highlighted that there would be a positive effect for those who wanted/needed in-person appointments as the health professionals' time would be freed up more to accommodate these - thus also reducing waiting times for this type of appointment:

> "Telemedicine increases the availability of in-person appointments for those who really need them which reduces waiting times and allows doctors to see more patients." (Individual)

Several noted that the reduction in waiting times was a positive step, not just for accessibility and convenience, but also for the woman's safety. They highlighted that there were fewer complications the earlier the procedure could be carried out. A few noted that EMA was a better option than surgical abortion, which would be needed if women could not access the service efficiently.

Negative Impacts

The majority of those who felt that EMAH had a negative or mixed impact on waiting times proposed that waiting times provided a positive aspect of the service, as it allowed time for thought and reconsideration. Respondents highlighted that shorter/no waiting times meant there was a lack of time for the woman to fully consider and reflect on their decision, and that there was a lack of time for counselling prior to finalising their decision and for information to be sought/provided on alternative options. Again, it was suggested that women may develop mental health issues as a result of regretting their decision or feeling that there was no alternative:

> "Having to wait is not a bad thing if it gives a pregnant woman the opportunity to consider the full range of options available to her and the risks involved." (Individual)

> "The majority of women (who had abortions before the pandemic) I speak to feel 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. This would suggest there is a downside to shortening the timeframe." (Organisation, Women or Abortion Support)

Some advocated for the provision of independent psychological support, with one respondent suggesting that access to this and other support services may have been reduced or become challenging. A few suggested that teleconsultations often felt rushed, with little discussion of the woman's circumstances and no information provided about alternative options, which was again seen as adding pressure to the woman to continue with the abortion and a sense that the whole process was hurried:

> "From what women have told me accessing support services for an unwanted pregnancy has been more difficult. With a number of women being offered abortion but not abortion counselling. It is important to remember that women accessing these services may be seeking support other than abortion, that they are not able to get in a timely manner… Women express the pain of an abortion they felt they were rushed in to, and live with the regret of a decision they were not well supported in making… Many women describe the telemedicine service as rushed and don't get the holistic care they should." (Individual)

In addition, some respondents (including a few who suggested the overall impact on waiting times were positive) cautioned that improvements in waiting times resulting from these arrangements did not necessarily equate to a better quality service. Again, concerns were raised over the risks and safety implications of the arrangements, such as the inability to confirm gestation and the associated complications that could arise from the medication being taken beyond the recommended 12 weeks, the inability to reliably check whether the woman has been coerced into having an abortion or has suffered from abuse more generally, and no in-person assessments or support being provided.

A few proposed that the evidence from service providers that EMAH had resulted in a reduction in the gestational age at which EMAs were taking place was unreliable as gestation was not verified. As such, they suggested the self-reported information from patients could be inaccurate, either unintentionally or intentionally.

No Impact

A few respondents who noted that the current arrangements had no impact on waiting times suggested this was because there was no significant waiting times created by the previous system/in-person appointments. It was felt that services had been accessible, provided in a timely manner, and that this had not been a limiting factor of the previous approach.

Impact on Service Providers

Q2. What impact do you think that the current arrangements for early medical abortion at home (put in place due to COVID-19), have had for those involved in delivering abortion services? (For example, this could include impacts on workforce flexibility and service efficiency.) - impact on those involved in delivering services

Impact on those delivering services

	All Respondents		Excluding Right to Life Campaign	
	Number	Percent	Number	Percent
Positive Impact	825	15%	825	30%
No Impact	40	1%	40	2%
The Impacts are Mixed	216	4%	216	8%
Negative Impact	3645	66%	865	31%
I Don't Know	583	10%	583	21%
Not Answered	228	4%	228	8%
Total	5537	100%	2757	100%

Similar to the impact on accessibility and waiting times above, two thirds (66%) of all respondents felt that the impact on those delivering services had been negative. When the Right to Life standard campaign responses were excluded, the proportions of those who felt the impact of the current arrangements had been positive and negative were more equal, at 30% and 31% respectively.

Again, respondents were offered the opportunity to provide qualitative details to support their response, with 3,859 providing such comments.

Positive Impacts

Those who perceived a positive impact on the delivery of medical abortion services focused primarily on flexibility and efficiency. They felt that the current arrangements were more accessible, responsive and efficient, and thus enabled service providers to make time savings while still offering quality care to women seeking an abortion.

As discussed above, respondents felt that EMAH would be more efficient because the telemedicine approach was seen as less time intensive and would free up practitioners' time allowing them to focus on other patients, where appropriate. Several respondents commented that, to date, telemedicine had allowed NHS services to provide abortion services with fewer staff without compromising the quality of care, as well as to redeploy staff to deal with COVID-19 (i.e. optimising staff time usage). Overall, less time being spent on face-to-face consultations was seen as contributing greatly to increased efficiency allowing medical practitioners to plan and balance in-person and remote patient care effectively.

Indeed, a common theme was that EMAH had allowed abortion care providers to dedicate additional time to support service users and patients with more complex needs who attended clinics in-person:

> "The availability of telemedicine EMAH has seen a greater number of women choose this option over hospital-based abortion care. This has reduced demand on acute gynaecology inpatient/day-care services, and has freed up staff capacity and facilities to provide care in a pressured service." (Organisation, Healthcare Provider)

Similarly, flexibility arguments focused on services being able to be more responsive to the needs of different women, allowing staff to undertake essential on-site clinics and counsel others via teleconsultation. This was felt to be of benefit to both patients and providers in making services client-centred:

> "Staff report the advantage of being able to spend more time with those with more complex needs including those who do need to attend clinics in person." (Organisation, Healthcare Provider)

In addition, the introduction of self-referral for telemedicine was seen as reducing pressure and time-demands on GPs and local sexual and reproductive health services that sometimes refer patients for EMA.

Other positive impacts included the reported reduction in gestation at the time of treatment that the current arrangements had led to, as well as corresponding decreases in complication rates. This reduction in complications could increase doctors' and nurses' availability and therefore care opportunities for patients with more complex abortion and related sexual health care needs. Similarly, it may reduce the number of patients who attend for surgical abortions and therefore free up availability in abortion clinics. It was also suggested that the removal of routine scanning generated less distress, as it was noted that this can be invasive as well as physically and emotionally challenging for clients and service providers, by proxy. There were some views that more efficient access to early intervention may provide wellbeing benefits, i.e. by minimising complications, leading to safer practice and outcomes, with less distress for patients overall which would, in turn, reduce stress experienced by staff.

Other wellbeing benefits identified included reduced trauma and unnecessary stress to service providers linked to discomfort of face-to-face contact when discussing sensitive and often distressing personal circumstances. The

telemedicine approach was also seen as beneficial as it could limit involvement for those professionals who are potentially uncomfortable with the process for religious or other reasons. Indeed, conversations were described by some as being easier for both patients and staff if transacted remotely or in the comfort of a patient's own home/practitioner's own workspace, potentially making consultations more patient-focused. It was stressed that, removing the need to attend in person would provide protection and reinforce confidentiality to all:

> "Anecdotal evidence from those providing consultations suggests that many people have felt more free to talk and that there has not been a negative impact on the quality of consultations." (Organisation, Healthcare Provider)

Comments linked to efficiency again focused on the notion that telemedicine was more accessible to a wider selection of women who need it from a range of different situations and areas:

> "The change has enabled services to provide safe and effective services that are more accessible than ever before." (Organisation, Healthcare Provider)

The easier scheduling and greater certainty of telephone appointments was seen as helping workforce management, in addition to providing more opportunities to schedule telephone appointments and potential for improved timetabling. The telemedicine approach was seen as being more reliable than in-person contact, having associated benefits for service providers insofar as it reduced uncertainties linked to missed appointments, late running appointments, etc. and was therefore less negatively impactful on waiting times i.e. smooth running and more efficient clinics.

Being able to work remotely (rather than in dedicated clinics) was also seen as beneficial for medical staff to meet their own needs for flexible working arrangements both during the COVID-19 pandemic and longer-term. Several respondents suggested that the current arrangements should/could be extended to routinely offer video-consultation as standard practice to optimise engagement.

Finally, several respondents again noted that home facilitation and removal of the need for face-to-face contact had been essential in protecting medical staff from risks associated with COVID-19 (i.e. reduced transmission with healthcare workers not contracting COVID-19). It was felt this was one of the main positive impacts of the change for service providers. The reduction in on-site clinic appointments also offered added protection for patients who still need to attend in person:

> "Reducing in-person appointments also acts as an additional safeguarding measure for staff and patients during the pandemic as foot fall in healthcare settings has reduced, and social contact has therefore minimised." (Organisation, Professional Bodies)

Negative Impacts

The main view offered by those who felt there would be negative impacts on those involved in delivering abortion services was that removing the need for in-person consultation may be damaging to service providers if it depleted the relationship between the patient and the healthcare provider. One potential negative impact on the doctor-patient dynamic included not being able to ascertain sufficiently accurate information on which to help patients make their decisions. Another was not being able to provide sufficient psychological and other support once decisions have been made. It was suggested that removing in-person consultation would fundamentally alter the relationship between patient and physician to the detriment of both.

Specific common concerns included that service providers would not have the same confidence about consent and intentions of the patient compared to in-person contact, as remote consultations lacked the exchange of important non-verbal communication cues and were therefore less 'informative'. This was seen as particularly important where the patient did not have a good level of English or where other communication barriers existed (although it should be noted that the SACP guidelines make clear that such patients should be seen in person if they are unable to easily understand what is being explained).

Concerns were raised that it would be less clear to practitioners if a patient was fully informed before making their decision (and able to offer fully informed consent) or if they were being coerced into an abortion (including in cases where women were living in abusive or exploitative relationships). It was felt that staff would not be able to guarantee remotely if the patient was being given the opportunity/freedom to speak with their medical practitioner in private. Indeed, this was the most frequently cited concern as it was seen as having potentially negative impacts on whether practitioners could do their jobs with confidence:

> "It is not known who else is in the room at the time of the call and if the woman is being coerced… This puts healthcare workers in a very difficult position. Firstly, legally as we have safeguarding obligations and a duty of care that cannot be safely provided through a telemedicine service. Secondly, this has huge moral complications, and healthcare workers may have to live with the guilt of being involved in a forced abortion or not stopping abuse." (Individual)

It was suggested that patients may not communicate any questions or concerns as openly via teleconsultation and this may be hard for a nurse or doctor to assess without seeing body language. Similarly, it was suggested that healthcare providers may experience decreased confidence as the lack of personal consultation would hinder informed health and risk assessments (i.e. making it challenging for medical personnel to do their job thoroughly). Duty of care should not be compromised, it was stressed, and NHS staff should not feel disempowered by virtual approaches.

Potential for deskilling was also raised by a minority, with suggestions that the current arrangements undermined the skill and expertise required to ensure that abortion decisions were appropriately facilitated:

> "The loss of independent medical advice shows a lack of understanding of the efficacy of trained, skilled involvement in the process. It has given rise to anxiety on the behalf of staff where complications and thus recriminations against them have arisen." (Organisation, Pro-Life and/or Faith Groups)

Concerns were also raised about the risks, stress and anxiety for healthcare professionals (including potential for litigation) linked to being held accountable for the safety of patients in cases where:

- Medication is not taken appropriately or as directed;
- Medications are taken by someone other than for whom they are intended (including being given to very young women/girls);
- Positive pregnancy tests resulting from non-intra-uterine pregnancy/ectopic pregnancy being missed and associated (potentially fatal) consequences;
- Gestational age being inaccurately estimated/falsely disclosed, and associated negative consequences if the fetus is more developed; and
- Medical complications arise and/or a patient death is linked to the current arrangements (fatalities, in particular, could negatively impact the mental health of individual service providers, it was suggested):

> "Lack of definite control over the process must be stressful for medical practitioners with the risk of complications and subsequent litigation against the professionals involved." (Individual)

Concerns about negative outcomes for patients may be augmented when using remote communication approaches where providers must rely more heavily on the word of the patient, and this may undermine the providers confidence in issuing EMA medications, it was stressed. Medical professionals remain responsible for their patients' welfare, although at a distance, and it was suggested that the current arrangements may not lend themselves to good patient care, or protection of workers' mental health, thus eroding professional standards of care.

Other common responses included suggestions that medical professionals may feel that they have been unable to fully support the patient in their care when making significant life decisions, staff being concerned about being able to provide consistency and continuity of care, and apprehension about being able to offer sufficiently compassionate and patient-focused responses overall when using remote communications. Some felt that health professionals cannot perform their duty of care when separated from their patients:

> "Without an in-person appointment, there is no relationship between patient and caregiver, making clinical decision making harder. This is a dangerous precedent and puts an unfair weight of responsibility on the caregiver." (Individual)

Having facilities to allow nurses or doctors to routinely follow-up on remote consultations was suggested as a means of improving the service and mitigating against concerns for service providers that appropriate care is being given.

A lack of support for staff who morally, religiously or conscientiously object to abortions was suggested by a minority as something which would be potentially compounded by the current approach. It was highlighted that it was not clear whether medical professionals who have issues with the morality of abortion were able to have their freedom of conscience protected. Staff should have the option to decline participation, it was suggested, to avoid potentially negative impacts on individual service providers.

Other wider concerns for service providers considered capacity-related issues, specifically:

- Potential for increased demand on counselling and other care providers who manage post-abortion care for women using EMAH;
- Potential for increased attendance at A&E or other medical services in cases where EMAH has resulted in medical complications; and
- Potential for loss of jobs in abortion services if demand for in-person appointments decreases and the EMAH arrangement results in significant efficiencies.

A very small number mentioned job dissatisfaction as a potential negative consequence, e.g. if a reconfiguration of services results in changes to working practices it may have a negative impact on staff morale in some circumstances. This, in turn, may lead to high levels of staff turnover and present a challenge to the service provider workforce stability.

Mixed Impacts

Among those who felt that there would be mixed impacts, several highlighted what they perceived to be a process of making the system quicker and cheaper to the detriment of patients and providers (i.e. although improved efficiency, time and cost savings might benefit service provision, it was not necessarily positive since care was potentially being sacrificed). An assessment of efficiency would differ significantly, it was felt, based on the perspective from which it was viewed:

> "If efficiency is only to be regarded as how many pregnancies were ended, they have been efficient. But if quality of patient care is considered efficient, then the lack of person-to-person interaction and provision of pre- and post-abortion counselling means the current policy is seriously inefficient and negative from the receivers' point of view." (Individual)

Others highlighted that while the change may benefit service providers, employers or organisations (in terms of efficiency and potential staff and cost savings), this may be to the detriment of individual care practitioners who may find telemedicine approaches less comfortable, or more stressful, again due to lack of face-to-face interaction with their patients. It was felt that staff would need to be adequately supported to make a transition to virtual approaches:

> "While I imagine it allows for greater flexibility, efficiency and potentially reliability, I can imagine there are some delivering the

> service who find it hard to connect or support people adequately through a digital platform and maybe be resistant or require additional support in delivering the same level of care." (Individual)

The teleconsultation approach may be more emotionally draining, it was suggested, and more challenging as it places more demands on the professional to be alert to very subtle cues in the spoken word which might indicate if women are being coerced, etc. It was also suggested that additional resources for training (e.g. in teleconsultation and identification of gender based violence) may be required if remote approaches were to become embedded, which could counteract efficiencies achieved elsewhere.

Indeed, several medical practitioners highlighted that they had mixed views on the proposal. While recognising that it could be more efficient, several highlighted that they preferred, or felt more comfortable, meeting patients face-to-face in appointments to discuss abortions. They considered in-person consultations to be of greater benefit to both themselves and the patient:

> "As a nurse myself I would feel that a telephone appointment may well save me time but that I would not be providing holistic, patient centred care. I think a patient may feel less like they had other options than they would in a face-to-face appointment." (Individual)

A small number suggested that teleconsultation approaches may, in fact, not be quicker than face-to-face, as practitioners may spend longer discussing patients' histories and trying to reassure themselves that they are fully informed of all relevant background and context data to inform their remote assessment. Others highlighted that efficiency benefits may be outweighed by more time being needed to manage cases where the procedure does not go to plan.

While several felt that the current arrangements were appropriate in the short-term to counter the risks associated with COVID-19 transmission, they felt that it was not suitable as a permanent or long-term plan (usually on the grounds that the remote approach was inferior to face-to-face contact).

Other Perspectives

A small number of respondents indicated that they perceived there would be no impact. Among these, the main argument was that teleconsultations and face-to-face consultations should, in principle, entail the same planning, time and quality of care, making any impacts neutral.

Others suggested that questions focused on 'service efficiency' were inappropriate given the sensitivity of the consultation subject matter. Several others commented that they were not knowledgeable enough, or that there was insufficient information in the consultation paper, to provide an informed response on this matter.

Overall, while a notable number of respondents acknowledged that the current arrangements were probably more convenient for service providers, and would lead to efficiencies, there was consensus that the needs of service users should always be prioritised, both short- and long-term.

Risks of the Current Arrangements

The consultation paper sought feedback on the risks associated with the current EMAH arrangements, as well as any possible mitigation measures.

Q3. What risks do you consider are associated with the current arrangements for early medical abortion at home (put in place due to COVID-19)? How could these risks be mitigated?

Overall, 5,181 respondents provided a qualitative response to this question, consisting of 5,112 (99%) individuals and 69 (1%) organisations. It should be noted however, that 2,780 responses were from the Right to Life standard campaign and so provided identical information.

While the question sought feedback about both the risks and possible mitigation measures, most responses focused on identifying and discussing the risks.

Perceived Risks

A long list of perceived risks were identified, which largely mirrored the negative impacts outlined above. These included:

- The lack of direct medical supervision, and having no/delayed access to medical support should there be complications - with risks of serious complications including incomplete abortion, haemorrhaging, infection/sepsis, and death;
- The medication being taken beyond the recommended/legal gestation - both increasing the risk of complications for the woman and the risk of viable babies being born if the medication is taken later in pregnancy;
- The medication not being taken at the correct intervals - again risking complications;
- Ectopic pregnancies, twins or other health issues being missed, which could lead to dangerous complications;
- No way to identify whether patients are being abused/coerced or are victims of human trafficking, including being coerced/forced into having the abortion;
- No way to verify the identity of the patient or that they will be the true recipient of the medication;
- No way to verify where the medication will be taken, whether this is a safe environment, and whether appropriate adult support will be present;
- Some women or girls may not have a safe and private space to conduct the teleconsultation, to receive the medication or pass the pregnancy;
- Practitioners not being as able to establish whether the woman has made a fully informed decision or feels this is their only option despite wishing to continue the pregnancy;

- No evaluation of, or support for, the women's emotional/mental state before, during or after the procedure - it was stated there was a risk of severe issues, such as regret, shame, depression, substance misuse and suicide;
- Increased risk of future health issues for women, including future fertility problems, subsequent premature births, lack of access to anti-D prophylaxis for those who are Rhesus D negative[3] and the impact on subsequent births, and breast cancer;
- Women will feel rushed into the decision with no information/procedure for them to reconsider, and more limited opportunity to administer reversal medication should they change their mind after taking the first pill; and
- Lack of information and support available/provided on alternative options:

> "To go back to the basics of 'first do no harm', providing controlled drugs via a telephone conversation, to an unknown person, of unknown age or ability, with no method of verifying any of the information given, is neglecting our duty of care to pregnant women." (Individual)

A few respondents felt that the current arrangements went against previous guidelines, or allowed these to be avoided. For example, it was highlighted that women needed to be in a safe environment/at home, which they felt could not be ensured under the current arrangements.

Possible Mitigation Measures

Of those who suggested possible mitigation measures, some felt it was important to continue to provide the option of attending a clinic in-person to ensure those who are at risk, or more nervous of the procedure can be supported - it was argued that remote services should not become the only option.

Other suggested mitigation measures for the current EMAH arrangements included:

- Conduct thorough risk assessments and teleconsultations following strict questionnaires or guidance to ensure all relevant information is collected;
- Provide clear guidance to women on how and when to take the medication, and what to expect;
- Ensure women are provided with clear information about when they should contact services for further guidance, if they have any concerns, or experience any complications;
- Conduct routine follow-up checks via teleconsultation, and/or text services, for both medical and emotional purposes;

[3] It should be noted that NICE guidelines already recommend that Anti-D is not required for medical abortions where women are under 10 weeks' gestation. SACP guidelines also recommended that once Covid-19 is no longer considered a significant risk, women between 10 and 11+6 weeks should again be given Anti-D where appropriate.

- Facilitate calls at the point of taking the medication to guide and support them through it;
- Provide teleconsultants with additional training on identifying abuse and how to ensure the woman can talk safely and is not being coerced;
- Provide a full and complete support service: offer information about the practical and emotional effects of abortion; introduce better crisis pregnancy counselling; provide a means to link women to sources of support; and provide information and support for alternatives to abortion;
- Provide a dedicated 24/7 'helpline' to medical professionals and/or psychological support;
- Provide easy access to online and/or in-person options for counselling, both pre- and post-procedure;
- Provide a 'cooling off' period for women to allow them to fully consider their choices before taking the medication; and
- Provide the medication in discrete, unbranded/neutral packaging, and ensure child-proof packaging and storage instructions to ensure children do not mistakenly consume the pills:

> "Any medical issues that may arise… can be mitigated by the woman having direct access by telephone to a medical professional who can assess the situation and decide whether or not the woman needs to come into hospital to be seen. This should be no different to any other person who is currently experiencing a medical issue that they are managing at home, it happens successfully all the time." (Individual)

Conversely, many wanted an end to EMAH. Some suggested that the best mitigation against the risks was to return to the previous system, and in particular, to reinstate in-person consultations, with several suggesting that scans should become routine. Others preferred a move to a model where the full procedure would take place within a medical facility, and preferably one capable of dealing with the associated complications. Others wanted an end to all forms of abortion.

Arguments in Favour of the Current Arrangements

Those in favour of EMAH argued that there was no greater risk from the current arrangements compared to the previous system. They noted that, under the previous arrangements, the risks of mis-timed administration of the pills existed as patients were given the second pill to take at home, and medical/physical complications and emotional distress from the procedure would remain the same as the patient simply took the first pill in the clinic and was then sent home to pass the pregnancy:

> "I do not see any increased risks, as 24/7 service access is available if required. I consider the current arrangements less risky, as travel/contact/fear of stigma may all be reduced." (Individual)

Respondents argued that abortion was a low risk procedure which was best managed as medical care plans being established through collaboration between a woman and her clinical team. They felt that women's needs and wishes should be at the heart of reproductive healthcare, with several noting that the current arrangements had been found to be an acceptable model for most service users. They also argued that abortion should be regulated in the same manner as other medical treatments, i.e. that clinical risk should be managed by guidelines and regulation, not legislation. It was suggested that legal requirements which would not enable providers to tailor care to the needs and circumstances of individual women would result in some women being unable to access safe, legal abortion care:

> "Abortion, especially early abortion, is low-risk. It should be managed between the person requiring care and their medical team, and should have as few barriers in their way as possible." (Individual)

Many respondents from this cohort argued that the evidence showed that the occurrence of risks were rare and that high levels of safeguards and mitigation measures were already in place. Specific points made to support EMAH included:

- Low risk of complications - It was noted that evidence showed there was no greater instance of significant adverse events due to EMAH compared to the previous arrangements. Further, it was highlighted that providers had developed 24-hour advice lines and set out written information with the medications, often alongside the provision of pain management and oral contraception;
- Low risk of wrong gestation or inaccurate administering of the medication - Robust screening processes were said to be in place, with clear, consistent, verbal and written information provided to women. Respondents cited evidence which showed that the current arrangements were facilitating earlier abortions, and that women administering the medication beyond the recommended/legal limit was rare. They also highlighted that patient feedback showed that most women had felt that the procedure was straightforward, that they had enough information to take the medicines themselves, and had not been concerned about safety. Further, it was noted that self-managed abortions had been shown to be safe and effective up to 24 weeks:

  > "When human error does occur, it may be found that a pregnancy is further along than was initially believed. However, the most significant risk is not a clinical one, as it is highly unlikely that there would be medically significant consequences." (Organisation, Healthcare Provider)

- Low risk of ectopic pregnancies - Instances of undiagnosed ectopic pregnancies were noted to be rare. Respondents highlighted one study that had noted that treatment with mifepristone and misoprostol will have no effect on an underlying ectopic pregnancy, and so there was no clinical reason to require women seeking abortion to have an ultrasound prior to treatment. They also noted that, as women were not required to undergo routine

scanning for ectopic pregnancies before continuing with a pregnancy, it would be inconsistent and inequitable to make this mandatory for those seeking an abortion. Rather, they highlighted that the earlier the woman was assessed and conducted the procedure there was an increased likelihood of ectopic pregnancies being identified earlier than traditional pathways. Onward referrals were also routinely provided to early pregnancy units for those at risk of ectopic pregnancies for diagnosis and management;

- No requirement for a scan - It was suggested that clinical guidelines were clear that routine scanning (for either dating gestation or identifying ectopic pregnancies) in every single case was unnecessary, and indeed, there was no law requiring women to have a scan before an abortion;
- Identifying abuse/coercion - Staff had been trained to identify abuse and other areas of vulnerability, and were highly alert to, and dealt flexibly with, such situations. Indeed, they argued that service providers had reported that women who access their services were routinely asked whether they feel safe at home and domestic abuse was regularly disclosed to staff. It was suggested that some women felt more comfortable disclosing abuse from their own home. It was also felt that the existing system of telemedicine, with in-person care where necessary, provided the best options for women who were victim-survivors of sexual violence or domestic abuse, particularly where leaving home for in-person appointments could be unsafe. Further, it was noted that providers made referrals to social services and the police, and worked closely with local charities to support such women;
- In-person service remains available - In-person appointments were still available where needed or preferred, emergency care was also provided as required, and the telemedicine approach did not exclude women from seeking emergency and/or follow-up care from other sources if required;
- Continual learning – It was noted that the Scottish Abortion Care Providers were considering how all learning from the delivery of telemedical services could be incorporated into the future provision of care; and
- Avoiding unregulated approaches - It was proposed that women might be more likely to continue with an unwanted pregnancy or turn to unregulated providers (who operate outwith the protection of the Abortion Act) if they cannot get to a clinic and the telemedicine approach is not available.

Several suggested that the only risk was the temporary nature of the arrangements. They felt that EMAH was a common, safe and effective procedure, which improved access. As such, they argued that the arrangements should become permanent:

> "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… 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… regulations should allow telemedicine to become a permanent feature of abortion care provision." (Organisation, Women's or Abortion Support Group)

Impact Assessments

As a result of the Public Sector Equality Duty (Scottish Specific Duties), the Fairer Scotland Duty, and the Islands (Scotland) Act 2018, the Scottish Government must consider the potential impacts of any new or significant policy change on specific population groups. As such, the consultation document asked a series of questions to elicit respondents views on the potential impacts for each group of continuing the current arrangements for EMAH. These groups included:

- Equality groups, including people with the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation;
- People in different socio-economic circumstances; and
- Equality for women living in rural or island locations.

Impact on Equality Groups

Q4. Do you have any views on the potential impacts of continuing the current arrangements for early medical abortion at home (put in place due to COVID-19) on equalities groups (the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation)? - Impact on equalities groups

Impact on Equality Groups

	All Respondents		Excluding Right to Life Campaign	
	Number	Percent	Number	Percent
Yes	4611	83%	1831	66%
No	365	7%	365	13%
I Don't Know	400	7%	400	15%
Not Answered	161	3%	161	6%
Total	5537	100%	2757	100%

The majority of respondents indicated that they had views on the potential impact on equality groups of continuing the current arrangements (83% of all respondents or 66% of those excluding the Right to Life standard campaign responses). In addition, 4,658 qualitative comments were provided. Of those who provided comments, 484 (10%) felt the impacts were positive compared to 3,998 (86%) who felt they were negative. The remainder of the comments either outlined mixed impacts, did not clearly outline whether the impacts were considered to be positive or negative, or were not relevant to the question as they typically either outlined their preferred approach or advocated for an end to all abortions.

Pregnancy and Maternity

Many respondents felt that continuing EMAH would have a negative impact on pregnant women's physical and mental health. As discussed throughout the previous chapter, this included concerns that the following risks may apply:

- Risks around complications from the procedure which could impact their physical health, require further medical or surgical intervention, or result in their death;
- Risks to their mental health related to their decision or 'trauma' of the procedure;
- That little/no information would be provided on alternatives, and/or no moral or psychological support would be provided across the course of the procedure;
- Risks that the gestational period may be further along than expected, recommended, or legal for the procedure;
- That women may be being coerced or forced into the abortion, and/or that EMAH made it too easy for abuse to go unnoticed; and
- That women may face emotional or physical abuse if their partner or family found out about the abortion, which was felt to be more likely if the entire process happened at home.

It was suggested that this could create inequality in healthcare because some respondents believed that women were not being given the protection, medical attention or emotional support they required, and that they were not being adequately cared for.

However, others argued that fears over safeguarding had been shown to be unfounded. Rather, they argued that women had been more able to alert practitioners to abuse/coercion via the telemedicine model, and had been more able to access the procedure without their abuser finding out as they had not needed to visit a clinic.

In addition, several proposed that EMAH empowered pregnant women by offering a choice of access methods, providing women with greater autonomy, and making access to the service more confidential/private. These amendments were considered to support women to make their own decisions and be less impacted by external factors or other people's opinions/advice. It was also felt to have improved their safety as they were able to access the procedure more quickly, thus reducing the risk of complications. It was felt that EMAH was better tailored to patient needs and thus improved equality, particularly in relation to access, for women and pregnant people:

> "…maximising the options for delivery of abortion care is likely to offer the most opportunity for tailored care... Developing services that are gender-sensitive and intersectional requires the experiences and realities of diverse groups of women to be understood as these factors shape the capacity and resource to access reproductive healthcare in specific ways. The design of services is critical in

ensuring that every single person who needs it can access safe and free abortion." (Organisation, Women's and Abortion Support)

Disabled People

It was suggested that access to the service may be reduced for some disabled people, including those with hearing or sight impairments, and certain mental health issues. It was felt that teleconsultation methods would negatively impact the consultation experience and decision-making process for these women. It was also believed they may be more at risk of forced or coerced abortions.

Again, however, many others disagreed and felt that EMAH had created a more equitable and inclusive service by improving access for particular groups of disabled people. Similarly, it was suggested that women with certain mental health issues may benefit from EMAH, such as those who would find it difficult to travel to a clinic, cope with a face-to-face discussion or function in a clinical environment. It was felt that the current arrangements removed transport barriers and provided greater confidentiality (and provided equality in this respect with others) for those who would otherwise have to rely on others for transport or support to access the clinic and in-person consultation. Several argued that disabled people often faced discrimination when it came to accessing and experiencing reproductive services, but these new arrangements improved and facilitated access.

Several disabled people who responded to the consultation were in favour of the proposal to make the current arrangements permanent as they felt it would improve access for people in the disabled community who would find it difficult or impossible to access a clinic for an abortion.

Religion or Belief

In line with one of the concerns raised at Q2, many respondents felt that there was an impact for medical staff (and potentially post office staff and couriers) who may object to abortion on the grounds of religion or belief, but who may have to participate in the packaging and delivery of the medication. For example, it was felt that more ancillary, administrative and managerial staff could become involved in the distribution of the abortion medication, some of whom may be conscientious objectors, and it was felt they should benefit from Article 9 of the European Convention on Human Rights which protects freedom of conscience.

Others felt that the proposals to continue with EMAH went against their religious or pro-life beliefs - however, this typically applied to all forms of abortion rather than being related to the specific proposals in the consultation, other than these perhaps making it easier to access and thus potentially increasing rates of abortion[4].

Several respondents felt that women from particular faiths and religions would be more at risk of forced or coerced abortions given the lack of in-person consultation. Others however, believed that the current arrangements could be helpful in

[4] However, it should be noted that, while abortion rates did increase in March and April 2020, there has not as yet been an overall increase. See https://scotland.shinyapps.io/phs-covid-wider-impact/

supporting women within faith communities to access early abortion more discretely and within the timescale permitted by some religions.

Some in favour of EMAH suggested that the privacy offered also meant the service was more accessible to those from particular religious backgrounds where there is disapproval of pregnancy outside marriage and/or abortion, meaning the woman may be divorced, shunned or harmed as a result. As such, attending a clinic in person may be difficult and generate significant anxiety:

> "Some women will live in a religious or cultural community which does not support sexual activity outwith marriage and/or abortion. Telemedicine and EMAH supports women to access care discretely from their home setting, without the perceived risks and anxieties of attending a sexual health or pregnancy related service." (Organisation, Healthcare Provider)

Minority Ethnic Groups

It was suggested that EMAH meant there was a risk of introducing inequality for some minority ethnic groups. A few respondents highlighted that some minority ethnic groups were more likely to experience deprivation, and that this could predispose them to poorer health outcomes, which could be exacerbated by the lack of in-person care provided by the current arrangements:

> "…the lack of direct physical medical input which this legislation creates will place women from minority ethnic groups at higher risk of complications." (Individual)

Conversely, others felt that the current arrangements would make it easier for minority ethnic groups to access the service.

Some respondents suggested that EMAH would create communication barriers and problems in instances where the woman did not speak English fluently. It was felt that it could be difficult for the woman to understand all the information being provided via a teleconsultation, and would also be difficult for the practitioner to know if the woman had fully understood the information. However, others highlighted that interpreters can be involved in teleconsultations and that in-person appointments can still be requested/required. (It should be noted that the SACP guidelines make clear that women should be seen in person if they are not able to understand all the information given.)

Age

A few respondents registered concern that the current arrangements could impact young girls negatively. The lack of verification of the patient's identity and details could result in those under 18 requesting the medication and being alone when they are taken, and/or for the abuse of those aged under 16 to remain undetected. Again, other respondents disagreed, highlighting that providers were alert to the wider sexual and reproductive health needs of younger patients, and that services can still opt for in-person appointments in such circumstances (SACP guidelines are also clear that those under 16 should normally be seen in person). It was also

noted that as patients can access the service via their mobile phone, this may make it more accessible to younger patients and reduce the need for an in-person appointment which they may find more difficult to attend.

A few respondents argued that it may be challenging to ascertain if those under the age of 18 were providing fully informed consent. Others noted that informed consent may be an issue where patients were not proficient in English or for those with a learning disability:

> "…it is unlikely that they will have the same capacity for decision making, voluntariness and the ability to make balanced decisions as more mature adults. This means that they may not be able to give appropriate informed consent for certain momentous decisions requiring mature reflection." (Organisation, Other)

Other Equality Groups

Issues raised by respondents in relation to other equality groups included:

- Gender Reassignment and Sexual Orientation - EMAH was felt to have a positive impact on the transgender and wider LGBTI community due to the privacy it offered. Both transgender-men and non-binary people were reported to experience the typically female gynaecological healthcare setting as a barrier to access. It was highlighted that LGBTI people face more discrimination when accessing reproductive services, with EMAH seen as a positive step to overcome discrimination.
- Marriage and Civil Partnership - A few respondents felt that relationships were strained and negatively impacted by abortion generally, and the 'secrecy' that can accompany EMAH specifically. One respondent cited evidence which estimated 40-50% of relationships end following abortion[5]. A few indicated that they felt that the current arrangements and the consultation excluded the father from consideration.

[5] https://www.deveber.org/wp-content/uploads/2017/09/Chap15.pdf, p.218.

Impact on Socio-Economic Equality

Q5. Do you have any views on potential impacts of continuing the current arrangements for early medical abortion at home (put in place due to COVID-19) on socio-economic equality?

Impact on Socio-Economic Equality

	All Respondents		Excluding Right to Life Campaign	
	Number	Percent	Number	Percent
Yes	4576	83%	1796	65%
No	344	6%	344	12%
I Don't Know	352	6%	352	13%
Not Answered	265	5%	265	10%
Total	5537	100%	2757	100%

When asked if they had any views on the potential impact of continuing the current arrangements on socio-economic equality, most respondents indicated that they did (83% in total or 65% when excluding the Right to Life standard campaign responses). Overall, 4,590 provided qualitative comments, of which 564 (12%) suggested the impacts would be positive in nature and 3,840 (84%) felt they would be negative. Others again noted a desire to end all abortion practices or the temporary arrangements, or to continue with the current arrangements, or suggested that impacts would be felt by all women regardless of socio-economic status.

Positive Impact

Most respondents who felt the impact would be positive highlighted the many hidden costs and financial barriers to accessing in-person abortion services, including transport, overnight costs for those who have to travel significant distances, organising time off work/loss of income, and childcare costs. These barriers make it harder for those with lower financial means or without independent incomes to access abortion services. As EMAH reduced the need to travel and enabled women to control the timing of their abortion to avoid conflict with work and caring responsibilities, it was considered to provide greater equality of access to the service for those with low incomes and from lower socio-economic backgrounds:

> "Accessing abortion from home will increase choice for those in lower socioeconomic groups who may not be able to travel, take time off work or pay for childcare to attend a clinic in person." (Individual)

Insecure employment and zero hour contracts were also seen as a barrier to women attending in-person appointments, both in relation to the loss of income in the short-term but also potentially more long-term impacts. It was noted that turning

down shifts to attend appointments followed by several days off to complete the procedure could result in a longer-term impact on their earning potential - it was suggested there was a risk that a woman could see a significant reduction in her subsequent shifts or could even find she would not be offered further shifts. As the current approach reduced the need for time out of work, it was felt this positively benefited those in these typically lower paid and more insecure jobs, as well as those working multiple jobs or undertaking shift work.

It was suggested that the current arrangements help to ensure women can access regulated, safe and supportive abortion services rather than turning to unregulated providers. Respondents suggested that those who experienced financial barriers to accessing NHS services would be more likely to seek an alternative source, but that they may then be reluctant to come forward in the event of complications for the fear of being arrested. It was suggested they would be less likely or unable to benefit from the safeguarding, psychological support and contraceptive services provided by regulated providers:

> "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 facilitates better access to safe, regulated abortion care for socio-economically disadvantaged groups." (Organisation, Professional Bodies)

A few respondents suggested that the current arrangements could have longer-term impacts on women's socio-economic wellbeing. It was highlighted that reducing rates of unintended pregnancy could improve educational attainment, participation in the labour market, and reduce the risk of women and children living in poverty:

> "Taking control of when one becomes a mother gives women the freedom to work and improve their own economic position, unfettered by unplanned pregnancies or children." (Individual)

Several respondents highlighted data which showed that women from the most economically deprived areas were twice as likely to use abortion services compared to the most affluent areas[6], and suggested this meant that supporting them to access the services was highly important. Respondents also argued that attempts to revoke temporary approval changes would disproportionately affect women of lower socio-economic status.

[6] See Termination of Pregnancy Statistics 25 August 2020 - Data & intelligence from PHS (isdscotland.org)

Negative Impact

Many respondents felt that poverty could make women feel that an abortion was the only option. As noted above, they highlighted statistics showing that those from lower socio-economic backgrounds were twice as likely to seek an abortion[7], which they suggested demonstrates that poorer women were forced into abortion by their circumstances. They argued that EMAH put poorer women more at risk from what they considered to be an unsafe process, a lack of medical and psychological care, a lack of access to information, and a lack of follow-up care and support, and therefore did not provide equality:

> "Home abortions will disproportionately impact women on low incomes or in difficult circumstances, who may feel pressured to abort for financial reasons despite wishing to keep their baby. Poor women may also have less reliable access to support and resources than those from more privileged backgrounds, meaning they are only aware of alternatives to abortion when attending appointments - a process substantially curtailed by the current home abortion provisions." (Individual)

Respondents also argued that abortion should not be seen as a solution for poverty, and that the speed and ease of access could result in women taking the decision for purely financial reasons without having the time to fully consider their decision or alternative options. They suggested that women in deprived areas would be less likely to get the help they needed to deal with their circumstances and felt that more needed to be done to create the circumstances where women are supported to either keep the baby or access alternatives to abortion. It was felt that EMAH did nothing to help address socio-economic inequalities:

> "Allowing continuation of early (or later) medical abortions at home does nothing to address social inequalities. Other political and social reforms are necessary to adequately address such issues." (Organisation, Pro-life and Faith Groups)

A range of other issues, linked to socio-economic equality, were discussed by respondents and are outlined below:

- Some suggested women of lower socio-economic status could be more likely to suffer from domestic abuse or be victims of people trafficking. Therefore, it was felt they would be placed at greater risk of coerced or forced abortions, or could be at greater risk of sexual abuse as the abuser could end the pregnancy and conceal the abuse more easily via EMAH. It was also felt that the current arrangements provide missed opportunities to identify such abuse;
- Some suggested homeless women would be disadvantaged, either due to a lack of technology or fixed home address, as well as it being a missed opportunity to pick up on health issues that may not otherwise be addressed for women who are not engaging with routine GP check-ups (however the

[7] Ibid

Scottish Government approval and SACP guidelines are clear that women can only have abortions at home if it is the place where they are ordinarily resident, so homeless women are required to attend a clinic/hospital);

- Some discussed the impact of the digital divide, i.e. lack of access to the required technology and/or internet access, as well as a lack of private telephone facilities or a private space within the home as limiting access to EMAH for those from lower socio-economic households;
- A few highlighted that low socio-economic status often leads to lower health outcomes, and so women in lower socio-economic groups would be more likely to suffer from poorer health and have higher likelihood of complications - therefore being at greater risk from the EMAH arrangements; and
- A few suggested that those living in less-affluent areas, or with lower educational attainment levels, might not understand the information and instructions via teleconsultation (e.g. the way the medication should be administered, signs of complications, the risks of a home abortion), or be able to access emergency medical care or follow-up care should it be needed:

> "These women may not have a car to get to the hospital, a phone or credit to make a call for help… when complications arise. This puts underprivileged women at greater risk of harm." (Individual)

Several respondents called for the Scottish Government to publish abortion rates/data by area which would allow comparison by SIMD and also to present this data by in-person versus telemedicine methods of facilitation (however, it should be noted that Public Health Scotland does already publish abortion rates by SIMD in its annual abortion statistics).

Some respondents reiterated their concerns over the risks and impacts on women generally, without linking these specifically to socio-economic equality issues.

Impact on Women Living in Rural or Island Communities

Q6. Do you have any views on potential impacts of continuing the current arrangements for early medical abortion at home (put in place due to COVID-19) on women living in rural or island communities?

Impact on women living in rural or island communities

	All Respondents		Excluding Right to Life Campaign	
	Number	Percent	Number	Percent
Yes	4762	86%	1982	72%
No	299	6%	299	11%
I Don't Know	289	5%	289	10%
Not Answered	187	3%	187	7%
Total	5537	100%	2757	100%

When asked if they had any views on the potential impact of continuing the current arrangements on women living in rural or island communities, most respondents stated that they did (86% of all respondents or 72% when the Right to Life standard campaign responses are removed). In addition, 4,797 provided qualitative comments, of which 648 (14%) suggested these impacts would be positive, while 3,939 (82%) outlined negative impacts. The remaining respondents again typically felt that the current arrangements should be kept or removed, or indicated that equal access to safe medical facilities/procedures should be available to all, without relating any reasons for these standpoints to the impacts on those in rural or island locations.

Positive Impacts

Most of those who identified positive impacts felt that EMAH was an effective way to tackle the access barriers and improve accessibility for women in remote, rural and island locations. Due to the lack of locally available services, the barriers noted with in-person models discussed included:

- The distance women need to travel to access services - this was an issue in relation to the time needed to be away from home or work and potentially being required to explain this absence. In addition, the need for extended childcare was highlighted, along with the potential for women to have to undertake long journeys home after the appointment when they would be in a more vulnerable condition (i.e. experiencing nausea, vomiting, bleeding and/or emotional distress);
- The cost of travel, possible childcare costs, and overnight accommodation were prohibitive, particularly for women living on islands which required ferries or flights to the mainland;
- Difficulties in accessing suitable transport, including a lack of public transport, needing multiple interchanges to access services, or inconvenient/unsuitable times of public transport services;
- The lack of privacy from attending the local hospital or accessing facilities on the mainland. It was noted that there was a high likelihood of seeing someone they knew at the local facilities, while being away from home for an extended period would require arrangements to be made and be noticed by others in small communities, and so women may need to explain their movements more. Collecting medication from the local pharmacy was also considered to impact on confidentiality and privacy for women living in small close-knit communities; and
- Local GPs being conscientious objectors was identified as a potential difficulty in some rural and island settings, particularly where they were the only GP and it was hard to find others who could provide the required referral:

> “For those living in rural and island communities the longer distances of travel for in-person appointments, will have much greater financial impact. Also in close-knit communities individuals would previously have sometimes faced the difficulty of explaining the reasons for going to the mainland and being away. Allowing

> abortion medication to be delivered for home use gives the patient privacy and autonomy." (Individual)

Several respondents claimed that the most deprived women in island communities were the least likely to access abortion services, while the opposite was true for those on the mainland. It was argued that this showed that significant barriers (financial and logistical) existed for those living in remote, rural and island locations, which they considered the current arrangements went some way to alleviating.

Further, it was felt that EMAH reduced delays for women living in rural or island locations, both in the system itself and in women having the ability and/or confidence to seek the procedure quicker. As such, it was considered that the current arrangements ensured that EMA was feasible and safe for women in rural and island locations, and negated the need for higher risk, more invasive or unregulated options which may have taken place at a later gestation.

It was proposed that EMAH provided wider and more equal/equitable access to services for women who live in rural and island locations, as well as allowing them the same levels of control over their body and future:

> "For those of us in very rural communities this is like a lifeline of equality." (Individual)

> "Telemedicine and the availability of medication delivery will transform abortion care for women in rural and island communities. It will make it accessible, equitable and safer." (Organisation, Healthcare Provider)

Negative Impacts

Most of those who identified negative impacts highlighted that women in rural and island communities would be further away from emergency medical care should they encounter complications. They noted that serious complications can arise from EMAH, particularly in instances of later gestational use, but respondents highlighted that those living in rural and island locations were unlikely to be able to access emergency treatment in local medical facilities (should any exist), and so there would be a significant delay in accessing the necessary support:

> "Medical complications do sometimes occur with these medical abortions and haemorrhaging could become life-threatening for those who are distant from medical facilities and without transport. This arrangement is therefore an added risk for those living in rural or island communities." (Individual)

Various evidence was cited to support their argument about efficient access to emergency medical care, including reports which highlighted the lack of definitive critical care services within a 45 minute drive across the islands and Highland

Health Board areas[8], limited access to air/helicopter-based emergency services in some remote/rural/island locations[9] (which can also be impacted by inclement weather), and statistics around the proportions of women who access medical interventions following EMA (although the data was not based on Scottish experiences)[10]. However, it should be noted that these issues would typically arise as a result of complications which would occur after taking the second pill, and so would have presented a risk under the previous arrangements as well. As such, the issues would be common for all EMAs (and indeed other major medical issues or emergencies) and are not a direct result of the current EMAH arrangements, which was the focus of the consultation.

It was suggested that provisions for, and access to, mental health facilities needed for aftercare or ongoing support were equally limited for women in rural and island communities. Further, it was felt there may again be less privacy and more associated stigma for women trying to access these services in small communities:

> "If these women live in remote areas, they are unlikely to gain more support for their aftercare and mental health." (Individual)

A few respondents felt that women living in remote, rural and island areas may be more at risk of other factors which could impact on their decision/experience, such as abuse/coercion and isolation, as well as the lack of information provided about alternative options and the lack of support provided by EMAH. Therefore, several respondents felt that women in such areas may be more likely to feel there is no other choice but to have an abortion.

A few suggested that normalising abortion and increasing accessibility in such areas would result in declining populations locally due to declining birth rates. In practical terms, a few suggested that having good reliable internet access could be challenging in rural and island areas, as well as them being more likely to experience postal delays/disruption due to distance and/or weather, again limiting women's ability to access the service. Rather, several felt that in-person abortion services were preferable for women living in rural and island areas, but suggested that financial support could be provided to assist women to access these.

Overall, those who argued that EMAH had a negative impact felt that EMAH put women living in rural and island locations at greater risk, with any complications becoming more severe due to the delay in accessing assistance, and would, therefore, further entrench health inequalities and accessibility issues between rural and urban areas.

---

[8] Emerson P, Dodds N, Green D.R. and Jansen J.O., 2017. Geographical access to critical care services in Scotland. Journal of the Intensive Care Society. 19(1), pp. 6–14. Available from: https://dx.doi.org/10.1177%2F1751143717714948

[9] Ibid.

[10] Ni inimaki M et al. (2009) Immediate Complications After Medical Compared With Surgical Termination of Pregnancy. Obstet Gynecol 114:795-804. Available from: https://pubmed.ncbi.nlm.nih.gov/19888037/

Future Arrangements

The consultation document sought views on respondents' preference for EMA provision once COVID-19 was no longer a significant risk. The options presented included:

- Retaining the current arrangements, i.e. allowing women to proceed without an in person appointment and take mifepristone at home, where this is clinically appropriate;
- Reinstating the previous arrangements, i.e. women would be required to take mifepristone in a clinic, but could still take misoprostol at home where this is clinically appropriate; or
- Other suggestions.

Q7. How should early medical abortion be provided in future, when COVID-19 is no longer a significant risk?

Preferred Future Arrangements

	All Respondents		Excluding Right to Life Campaign	
	Number	**Percent**	**Number**	**Percent**
a) Current arrangements (put in place due to COVID-19) should continue	935	17%	935	34%
b) Previous arrangements should be reinstated	3360	61%	580	21%
c) Other	1151	21%	1151	42%
Not answered	91	1%	91	3%
Total	5537	100%	2757	100%

When asked about their preferred future arrangements, 61% of all respondents felt that the previous arrangements should be reinstated. However, this was again largely driven by the Right to Life standard campaign responses, with only 21% of respondents preferring this option when this campaign group was removed from the analysis. Rather, 42% of respondents preferred 'other' arrangements and 34% preferred that the current arrangements should be continued when the Right to Life standard campaign responses were excluded.

A total of 4,282 respondents provided qualifying comments, most of which were provided by those who preferred to reinstate the previous arrangements (n=3,004). However, it should be noted that this was driven largely by the Right to Life campaign responses, with 'other' options preferred by the majority (n=1,144) when these were excluded. Further, these Right to Life

respondents also outlined a preference for 'other' arrangements in their qualitative response despite selecting 'Option B' at the closed question element.

Retaining the Current Arrangements

Of those in favour of retaining the current EMAH arrangements post-COVID-19, 72 respondents provided additional qualitative comments (consisting of 55 individuals and 17 organisations). Typically, these respondents felt that EMAH was patient-centred, safe, effective, and accessible and as a result they saw no legitimate clinical or medical reason why this service should be withdrawn. Indeed a few suggested that removing this process would be a 'backwards step':

> "The current arrangements should be retained permanently. The service is safe, effective, and accessible - and enabling women in Scotland to make the right choice for them regardless of geographic, economic, or social constraints." (Individual)

Several did caveat, however, that it would still be important to retain the option for face-to-face appointments and treatment where required or preferred, and that quick and easy access to a scan (including creating local links for this provision) would be beneficial where this is necessary.

In terms of wider infrastructure needed to support EMAH, a few organisations argued that provision must be standardised across Scotland, that full information must be made available to patients (including information about alternatives and/or other support available), and that suitable after-care services (such as mental health provision) must be funded and made available.

A few organisations also emphasised the importance of reviewing data and disseminating any learning going forward.

Reinstating the Previous Arrangements

Of those who indicated that they were in favour of reinstating the previous arrangements, 3,004 respondents provided supporting comments, consisting of 3,001 individuals and 3 organisations. Again, it should be noted that this consisted mostly of Right to Life campaign respondents who actually described 'other' arrangements (and have been incorporated under 'Other Arrangements' below). As such, 224 other respondents provided comments in support of reinstating the previous arrangements.

These respondents typically felt that the need to have in-person consultations and take the first pill in the clinic/hospital provided valuable safeguards, including:

- Confirming patient identity/who is taking the medication;
- Confirming gestation and any risk of ectopic pregnancies;
- Being more likely to identify the need for and/or provide access to psychological support;

- The provision of a time delay to allow the patient time to think about their decision/options; and
- To provide the safe-space needed to discuss the patient's situation and alternative options free from any external influences.

Some respondents felt it was important for there to be follow-up consultations, with several suggesting these should take place within one month, confirm the dates the medications were taken, log any side effects experienced, and identify and facilitate access to psychological support where required. It was considered crucial that this information be available within the patient's medical records for future reference, and that general data collection and analysis should inform service improvement.

Other Arrangements

Of those who indicated they would prefer 'other' arrangements to be implemented once COVID-19 was no longer a significant risk, 1,144 provided qualitative comments. Of these, 1,111 were individuals and 33 were organisations. A further 63 respondents who did not provide an answer to the closed element did, however, provide a qualitative comment, many of which were consistent with those outlined below. The 2,780 Right to Life responses are also outlined below.

A considerable proportion of respondents simply reiterated their concerns with EMAH, previous arrangements, or with abortion more generally without outlining any alternative suggestions regarding future arrangements. Many others stated that, going forward, all forms of abortion should be abolished and the Abortion Act 1967 repealed.

Where alternatives or suggestions related to future arrangements were provided these ranged from offering a mix of methods through to withdrawing the use of medical abortions entirely. The range of suggestions are outlined below:

- Offer a blended approach with both in clinic and at home options (or a mix of both) available, depending upon risk levels and the patient's preferences:

  > "A combination of both should be permitted. Where women wish and are happy to take the medication at home, I see no significant detriment to this. However, for those who would be more comfortable doing so in a clinic, I believe this should also be an option." (Individual)

- At least one in-person consultation should be required (with a few suggesting this should include an ultrasound scan) but both pills could be taken at home if appropriate;
- Both pills to be taken within a clinic/hospital setting;
- Full process to take place within a suitable medical facility;
- Greater psychological support provided;
- Greater information and support services made available so that those with a crisis pregnancy do not consider abortion to be their only option;

- Greater resources, as well as increased information provision and signposting, for adoption and support for families to keep their children;
- Greater resources put into sex education and contraceptives;
- Provide more information (with some suggesting the need for a public campaign) to inform women of the risks involved in having an abortion, including consideration of the potential for long-term psychological effects;
- Encourage the patient to see the pregnancy as a 'living child', so they understand the gravity of the decision;
- Greater restriction on eligibility for abortions (both medical and surgical), for example only available in exceptional circumstances, where all other options have been explored, or where the mother's life is at risk or in rape or incest cases;

  > "Abortions should not be made to be as easy as possible. It should actually be as difficult a process as possible and an action of absolute last resort." (Individual)

- Stop all medical abortions and only facilitate surgical abortions.

Preferences of those with Lived Experience

Forty-six respondents identified themselves as having had an abortion at some point in the past, or as having closely supported someone through an abortion. Of these, 21 (46%) felt that the current arrangements should be retained, six (13%) wanted the previous arrangements to be reinstated, and 18 (39%) suggested 'other' options. One respondent did not specify a preference.

Of those who selected 'other' arrangements:

- Five indicated a preference for either EMAH or all abortions to be ceased;
- Four wanted there to be a patient-made choice between in-person and at home provision;
- Four felt there needed to be better information given to women, particularly in relation to the risks associated with the procedure;
- Three wanted either the full procedure to take place in a clinic/hospital or for both sets of pills to be taken in a clinic/hospital, (a further two who preferred an end to all abortions indicated their belief that, should the practice continue, it would be better for EMA to take place in a clinic/hospital);
- One felt that one in-person appointment should be required; and
- Two did not outline any alternative approaches[11].

[11] A few respondents identified more than one suggestion.

Other Comments

A number of respondents provided comments and discussion on issues which were not directly related to the consultation questions or specifically related to the current EMAH arrangements. These were generally related to compliance with the Abortion Act 1967, issues with abortion/EMA generally, and perceived gaps in the consultation. These issues are outlined below.

Divergence from the Abortion Act 1967

Several respondents felt that the current EMAH arrangements, and the proposal to make these permanent was moving further away, or too far away, from the original intentions of the Abortion Act. It was felt this was intended to ensure the procedure was conducted or overseen by qualified medical professionals and should not be something that women undertook themselves. However, there was a sense that EMAH removed many of the safeguards and controls, and that medical professionals could not now be considered to be supervising the procedure (as is required by the law):

> "The women relying on posted abortion pills have been abandoned. There is no person-to-person contact. No effective, competent consultation. No secure follow up, when there are difficulties. One of the reasons why abortion was legitimised in the first place was to avoid back street abortions. Home abortions don't appear to be much different." (Individual)

It was also suggested that the Abortion Act 1967 was not intended to improve accessibility or to provide abortions 'on demand', but was designed to make the procedure safer. As such, it was felt that EMAH was no longer in keeping with the letter or spirit of the law, and they noted that the majority of abortions were now carried out for what they termed 'social' reasons and because the pregnancy was an 'inconvenience' rather than due to truly life threatening conditions for the mother:

> "I totally believe that there are exceptional circumstances where aborting life can and perhaps, regretfully, should be used. But never for convenience, for budgeting, for 'freedom of choice' etc." (Individual)

> "The vast majority of abortion in Scotland is preventable "social" abortion." (Organisation, Pro-Life or Faith Group)

Rights of the Fetus

Many respondents (typically those opposed to EMAH and abortions more generally) felt that the consultation had overlooked or excluded the rights of the fetus or unborn child. Generally, they believed that life begins at conception, and therefore the unborn child has the right to life and that they should have their rights protected by the Government. They also felt that the Government had a responsibility to protect the most vulnerable (in this case the unborn child), and those with no voice of their own. There was a strong sense among these

respondents that by excluding consideration of the fetus within the consultation, and moving to a system of EMAH, this failed to recognise that a human life was being taken by the procedure, and it was perceived that this cheapened the value of human life:

> "Life itself is being set aside as something with no recognisable value." (Individual)

> "Telephone/video conferencing reduces the protection for the unborn child written into the original legislation." (Individual)

Inappropriate Use

In addition to concerns that EMAH did not comply with the requirements of the Abortion Act 1967 and was being used too widely, many felt that that it was being used inappropriately. They generally felt that it was being used as a method of contraception, which they considered to be inappropriate.

Many respondents reported that fetuses with fetal anomalies were often aborted. In particular, it was suggested that abortions were routinely undertaken for non-life threatening disabilities, such as Down's Syndrome, and that clubfoot and cleft lip were other conditions which could trigger the decision to terminate a pregnancy. It was felt by some respondents that this was discriminatory and sent wider societal messages that such life was of less value. While it should be noted that this was an issue for abortion generally, and not specific to the current arrangements, a few did suggest that the lack in-person contact involved in EMAH could allow such selective abortions to increase (however, it should be noted that the diagnosis of such conditions would only be made following an in-person appointment).

Similarly, some respondents felt that the current arrangements, and any continuation of these, risked increasing sex-selective abortions (it should be noted, however, that abortions are not permitted under the Abortion Act 1967 for sex-selective purposes). It was suggested that some scans/tests could determine the sex of the baby at under twelve weeks, and this could result in some people electing, or being forced, to have an abortion on this basis. In situations where a woman is coerced or forced into a sex-selective abortion, it was felt that the lack of in-person consultation could result in such instances going undetected.

Issues/Risks from EMA Generally

Throughout the consultation responses, some respondents discussed issues, concerns or risks that would be expected to arise from EMA generally, and/or were common issues for both the previous and current arrangements. These related to physical and mental health risks.

In relation to physical health, many noted that EMA was a painful and traumatic experience for women, which carried the risk of excessive bleeding, haemorrhaging, ruptured ectopic pregnancies, incomplete abortion, infection/sepsis, renal failure and, in extreme circumstance, death. It was felt that women would not know when the pain or bleeding experienced was outwith normal

limits, which could lead to delays in seeking urgent medical attention. This was considered to be particularly risky for women who were alone with no one to help and support them. Indeed, a few noted that, while the former Scottish Abortion Care Providers guidelines stated that women should not be alone when taking misoprostol (i.e. the second pill)[12], the at-home method of administration meant there was no way to ensure this requirement was adhered to (however it is important to note that current 2020 SACP guidelines note it is optional for women to have someone with them). A few also suggested that women may have difficulty falling pregnant in future, that the procedure could result in disabilities in future children, or that there was a risk of the premature birth of viable babies if the pills were not used appropriately or within the recommended/legal gestation periods.

In relation to mental health risks, it was felt that women would find it particularly traumatic to expel and then dispose of the fetus themselves. This issue also raised wider hygiene concerns. A key concern was that the at-home approach introduced the potential for inappropriate disposal of fetal tissue. Again, as women were already passing their pregnancy at home under the previous arrangements, this is not a new issue created by the move to the EMAH arrangements.

Another issue discussed by a few respondents, which related to EMA more generally, was where women may want to reverse their decision after taking the first pill. A few respondents suggested that greater levels of advice and information on this should be provided as the reversal process should be started within 48 hours of taking the first pill. However, a few others noted that the effectiveness and safety of this reversal treatment had not been proven.

Wrong Focus

Some respondents felt that abortions and EMAH did nothing to understand or support women with their underlying reasons for seeking an abortion. They noted this could often be as a result of personal difficulties, abuse or financial pressures, and which women would still not be supported to address or overcome by accessing abortion services:

> "Women in crisis should be offered treatment and support for their reasons for wanting an abortion. Whether that is psychological trauma, their economical struggles and protection from abuse rather than encourage them to take a view that it is the baby that must be the problem. Abortion doesn't fix any of those problems." (Individual)

A few respondents claimed that the numbers of abortions taking place was very high and rising. As such, they felt that the Scottish Government should be more focused on understanding the reasons for this, tackling the root causes of abortion, and providing better holistic support to those experiencing 'crisis pregnancies' rather than continuing to support such high rates of abortion without question:

[12] https://www.sehd.scot.nhs.uk/cmo/CMO(2017)14.pdf, p.5.

> "This is a moment to reassess abortion services much more widely through the lens of protecting and promoting the human dignity of both women and their unborn children... Rather than simply widening access to abortion, there is an opportunity in the rebuilding of services to address the systemic reasons women are seeking abortions for example due to poverty or lack of relational support." (Organisation, Pro-Life or Faith Group)

Several believed that the move to EMAH would lead to increases in abortion rates due to the easier access and lack of alternatives this approach offered. However, they felt this created a disparity between the EMAH model for abortion and the rest of the COVID-19 response. It was argued that the COVID-19 response had generally been heavily focused on saving lives, yet they considered the EMAH response was making it easier for medical abortions to end the life of what they perceived to be 'unborn babies'.

In relation to COVID-19 restrictions, it was suggested that consideration needed to be given to access to contraceptives during the pandemic and restrictions that had been put on these (particularly long-acting reversible contraception (LARC)). It was suggested that access to these was extremely curtailed due to NHS reprioritisation, and therefore, it could be expected that there would be increased need for abortion services in the short to medium term as a result.

Lack of Robust Evidence

Several respondents highlighted that relevant data and evidence was not included within the consultation document. It was noted that problems were acknowledged without being supported by any data/evidence, and where other data/evidence were alluded to, no details were presented. This included feedback from NHS Boards on the experience of EMAH, and data relating to the medical and psychological safety concerns and unintended consequences of home abortions in Scotland (i.e. since the second pill (misoprostol) could be taken at home prior to the pandemic). It was argued that there was a lack of data/evidence on the impacts of taking the first pill (mifepristone) at home - i.e. one of the major changes of the EMAH approach. As such, respondents felt that greater data and evidence needed to be made available in order for the consultation to be considered fair, open and transparent, and for informed views to be developed regarding the impact of EMAH and its continued use:

> "The Consultation is lacking quantitative evidence on the problems associated with medical abortion even though SG [the Scottish Government] recognises them, and so is flawed." (Organisation, Pro-Life or Faith Group)

It was suggested that the evidence that had been cited in the consultation document was incomplete, had not been fully analysed, came from a narrow range of sources, or was subject to potential conflicts of interest. In particular, it was suggested that data from abortion providers would be biased towards satisfied patients as those who had negative experiences would be less likely to engage with the service again. It was also highlighted that one study cited had been conducted

by practitioners or academics involved in abortion or family planning and some argued that it could not, therefore, be considered truly impartial. Further, it was argued that robust and reliable data had not been presented which could provide reassurances around safety:

> "The claim that the process is safe is not supported by substantial evidence, evidence that is alluded to is without academic reference and data supplied has, in the papers own words, 'not gone through the same robust checking process as official statistics.' Claims of safety cannot be made and should not be made… when it cannot be fully and accurately substantiated." (Individual)

Ultimately, several respondents felt that the EMAH approach had not been sufficiently researched or had proper scrutiny to warrant making it permanent at this stage. Rather, it was argued, it would be preferable to wait until more data was available from across the COVID-19 period before taking any decisions about future arrangements.

Consultation

A few respondents were concerned about the methods being utilised to consult and debate on such a significant issue/change. It was felt that a much wider and more meaningful debate was needed, with others suggesting that greater consultation needed to be undertaken with the medical profession in order to seek feedback and to better understand their experiences and concerns. A few raised concerns about the nature of the consultation questions being asked. It was felt that these focused on a narrow set of issues and did not provide sufficient weight and importance to key areas of concern.

Support for EMAH

Finally, it should be noted that several respondents did outline support for the EMAH approach, noting that it could be considered a positive and progressive step which had been demonstrated to be successful:

> "This service is the gold standard in women's abortion care and [is] to be applauded... I strongly believe that the services must continue after the pandemic and that we should not reduce and make access more difficult to the delivery of abortion care in Scotland by denying women an option that has been proven to meet their needs." (Individual)

> "The provision of abortion pills for home administration is a long overdue and progressive step forward. One which is in line with modern medicine and clinically safe." (Organisation, Women's or Abortion Support Group)

Conclusion

The public consultation exercise elicited feedback from a large number of respondents, covering both individuals and organisations with an interest in the provision of EMAs.

The number of those against EMAH was significantly higher than those in support of it. However, it should be noted that a large number of the respondents who were against EMAH had either submitted a campaign response or had been influenced by one of several campaigns organised by pro-life or faith groups. Further, a significant proportion of those against EMAH were also against any and all forms of abortion and, as a result, some of the concerns raised were more applicable to abortion generally, rather than being specifically related to EMAH.

Common Issues

A range of views were offered consistently throughout the consultation questions, with feedback being split generally based on whether respondents were supportive or against EMAH. This was true for both individuals and organisations, and so differences were largely observed on this basis rather than between individuals and organisations or by organisational sector.

Common Concerns

Key areas of concern for women and pregnant people accessing EMAH, which were discussed in several areas across consultation responses, included perceived reductions in safeguards with regards to both the administration of the medication and the physical and psychological safety of the patient. It was argued that the EMAH method removed too much of the oversight and control from medical professionals and placed women at much more risk as a result. Respondents also felt that the EMAH approach did little/nothing to support women with any immediate or future psychological impacts (which were either related to their reason for the crisis-pregnancy, or resulted from undergoing the abortion).

It was felt that the EMAH model did not provide sufficient information or support for women to access alternative options/services which may be more appropriate for them, and did nothing to tackle the root causes of crisis-pregnancies in order to provide a longer-term and more positive outcome in the future. Rather, many considered that it provided a ‘quick-fix’ which was largely inappropriate.

Reasons for Support

Those who were largely supportive of the EMAH approach argued that this was safe and involved no greater risks than the previous EMA model (indeed some argued that EMAH could be safer), that complications were rare, and that the teleconsultation method had been demonstrated to be successful in identifying (and had provided patients with the confidence to disclose) abuse and coercion.

They felt it provided a more patient-centred service where women were afforded greater autonomy over their bodies and healthcare. Indeed, a few suggested it

helped to redress the way women were treated within a patriarchal society/system. Further, EMAH was considered to provide greater access, particularly for vulnerable patients and those who had previously found access to abortion difficult or impossible. EMAH was applauded for meeting the aim that 'abortion services should be accessible and free from stigma' as EMAH had improved accessibility, but also allowed patients to avoid the judgment and 'harassment' of pro-life/anti-abortion campaigners who can be gathered outside abortion clinics.

Going Forward

Preferences were split in terms of what the arrangements for EMA should be once COVID-19 did not represent a significant safety risk. There was a clear preference for the previous arrangements to be reinstated when all responses were considered. However, this was driven largely by the Right to Life campaign, and respondents in this cohort wanted tighter restrictions with the administration of both sets of medication being supervised in a clinic/hospital (and so does not truly represent a return to the previous arrangements). When looking at the responses of the other respondents, there was a reasonably even split between those wanting to retain the current EMAH model and those who sought 'other' models - which ranged from the provision of a blended service offering, providing more information and support, through to returning to a more clinically based approach or even revoking the Abortion Act 1967. Even for those who supported EMAH, however, it was important that choice was provided, and therefore, it was felt that both in-person and at home methods should continue to be offered.

Overall, the consultation elicited considerable levels of feedback on the EMAH approach and preferences for future provision. The Scottish Government intends to consider this feedback, alongside any other evidence that is available, ahead of making any decisions as to the nature of future EMA provision. However, it should be noted that several respondents felt that the consultation paper lacked sufficient details regarding robust data and evidence, and so there may be a case for delaying any decision on the future arrangements (after COVID-19 no longer presents a significant risk) until more data becomes available and greater levels of research have been undertaken to establish the impacts of the current EMAH arrangements.

Appendix A Campaign Synopsis

Right to Life - Standard Campaign Response

In total, 2,780 standard campaign responses were received which followed the Right to Life template. Below is an overview of the content from these responses.

Q1a. Impacts of the current arrangements for EMAH (put in place due to COVID-19) on women accessing abortion services? - Safety

In response to the quantitative element of this question, respondents stated the impact would be 'negative'.[13]

Respondents provided a very lengthy response at this first question covering various topics as follows:

- EMAH can lead to complications that put women's health at risk - respondents outlined the range of complications, described instances of these having happened, and suggested there was a risk that complications were under-reported;
- Risk of coercion & inability to identify domestic abuse - it was felt that the lack of verification of patients' identity left the current arrangements open to abuse/fraudulent use, and that teleconsultation methods were not suitable to identify coercion, abuse, or those feeling forced into abortion by others. It was felt that in-person consultations provided a safe space for women to discuss their situation, thus creating an essential safeguard;
- Impossible to accurately diagnose gestation electronically - it was highlighted that it is impossible to verify gestational age via a teleconsultation and patients could provide inaccurate information in this respect. Again, respondents highlighted the complications that could occur as a result of EMAH being undertaken beyond the recommended/legal gestational limits;
- Risk of complications increases as gestation increases - it was highlighted that the websites belonging to abortion providers note the risk of complications increases with gestational age. Respondents also stated that the rate of hospitalisation for complications increases with gestational age. It was felt that the current arrangements made it too easy for patients to, intentionally or unintentionally, provide an inaccurate date for their last menstrual period (LMP), thus placing their health and safety at risk. As such, respondents called for in-person appointments to be required before the medications are administered;

[13] It should be noted that the campaign responses received stated 'Positive Impact' at this question at the closed element, but all comments provided at the open element discussed negative impacts throughout. As such, it was assumed that the 'positive impact' rating was an error on the campaign template and therefore amended within this report to ensure the intentions of the campaign are communicated.

- It is not guaranteed that recommended protocols for taking abortion medication will be followed - it was suggested that the current arrangements placed the responsibility on the patient for monitoring dosing intervals and managing their preferred administration method, as well as monitoring various other aspects related to side-effects and complications. However, it was felt that the inability to verify an accurate gestational date may result in a patient applying misoprostol in a potentially unsafe manner, thus heightening the risks of medical complications. Further, they suggested that there was poor compliance with the adherence to instructions for self-administered medical treatments generally. In addition, they argued that there was a distinct lack of high-quality research study designs in EMA and risks of bias in existing data on EMAH;
- Testimonials from women who suffered complications and/or negative experiences of EMAH - testimonials from three women who had experienced complications or negative experiences during EMAH were presented. The respondents acknowledged that some of the effects and complications would have been the same in a clinical setting, however, they argued that having access to immediate medical support would be more appropriate patient management; and

Across most of the concerns raised, multiple sources were provided to corroborate the claims being made. This included UK Government statistics, research studies and reports (largely from Northern Europe/ Scandinavian countries), the results of mystery shopping studies which focused on obtaining EMAH medication from providers in England, the views of various medical professionals, and newspaper reports.

Q1b. Impacts of the current arrangements for EMAH (put in place due to COVID-19) on women accessing abortion services? - Accessibility and Service Quality

In response to the quantitative element of this question, respondents stated the impact would be 'negative'.

Respondents highlighted that not all individuals would be able to access telemedicine and felt that it had a disproportionately negative impact on accessibility for the most vulnerable populations.

In addition, respondents suggested that patients who did not have a good level of English and those with mental health problems and disabilities were disproportionately excluded by telemedicine. It was indicated that individuals may not feel comfortable talking about their mental health online, or may not be in an environment where they are safe to talk about their psychological wellbeing. Further, it was argued that some women would likely need far greater support (advice, psychological support, etc.) than could be provided during a teleconsultation. Respondents felt that women's health and safety was not been prioritised by EMAH. It was felt that in-person checks were crucial to provide the highest standard of care, particularly for those struggling with mental health issues or domestic abuse.

Respondents also cited polling which showed women wanted more, not fewer, safeguards around abortion across a number of key areas. In particular, the polling indicated a preference for in-person verification that each patient seeking an abortion is not under pressure from a third party, and that every woman requesting an abortion should be seen in-person by a qualified doctor.

Q1c. Impacts of the current arrangements for EMAH (put in place due to COVID-19) on women accessing abortion services? - Waiting Times

In response to the quantitative element of this question, respondents stated the impact would be 'negative'.

It was suggested that the reduced waiting times which had been facilitated by EMAH was not a positive outcome. Firstly, it was suggested that gestation was not being validated by ultrasound scans, and that women may be providing intentionally or unintentionally incorrect information on their gestation. These potentially inaccurate gestations could invalidate the claim that EMAH leads to abortions being undertaken at earlier gestations. Further, it was suggested that the data itself did not fully support the claim that EMAH had led to women having earlier medical abortions. Rather, they felt that changes reflected a pre-existing longer-term trend. As such, they felt the data presented did not justify the extension of the current arrangements.

The Right to Life standard responses noted that the effects of COVID-19 on abortion practice had yet to be thoroughly examined, and indicated that it was as yet unclear what impact the pandemic had had on who is getting pregnant, the prevalence of pregnancy and who is choosing abortion. Therefore, they suggested that, even if the data were reliable, the availability of EMAH may have had little to do with earlier termination rates.

Respondents stressed that expediency was an inappropriate measurement for a life-changing decision. They felt that prioritising speed and procedural efficiency disregarded the duty of care owed to women facing unplanned pregnancies. Rather, it was considered vital that women should be offered independent psychological support and a consideration period of 48-hours. They highlighted a study which indicated that 93% of women agreed that those considering abortion should have a legal right to independent counselling from a source that had no financial interest in the decision (although it should be noted that NHS Boards provide all early medical abortions in Scotland and their psychological support services have no financial interest in women's decisions on abortion).

Q2. Impact of the current arrangements for EMAH (put in place due to COVID-19) on those involved in delivering abortion services?

In response to the quantitative element of this question, Right to Life standard respondents stated the impact would be 'negative'.

It was felt that removing in-person consultation fundamentally altered the relationship between patient and physician. They highlighted research on nonverbal communications which suggested that the majority of communication (55%) is done

through body language[14], and therefore, teleconsultations may hinder communication between patient and medical practitioner. They also noted that a survey on GP remote consultations (published in December 2020) showed that most of GPs surveyed felt that remote consultations with patients were hindered by technical difficulties[15]. Respondents suggested communication challenges are accentuated in cases where there may be a language barrier, wherein the physician and patient may not be confident that they have understood each other and that the patient has provided fully informed consent.

In addition, respondents felt it was not evident how medical professionals are equipped to ensure that a woman is providing informed consent for an abortion of her own free will - potentially placing health professionals delivering abortion services in a difficult and compromising position.

The final area of concern focussed on the medical professional's responsibility, both for the procedure in general, and in particular for the disposal of the fetal tissues. Further, they suggested it was not clear from the consultation paper whether the registered medical professional would still be legally responsible for the procedure while it happens at home.

Q3. What risks do you consider are associated with the current arrangements for EMAH? How could these risks be mitigated?

Similar to Q1a, the Right to Life standard respondents provided a significantly lengthy response at this question. Three main issues were discussed, as outlined below:

- Risk of abortion coercion - it was felt that coercion would be impossible to detect without an in-person consultation as there was no guarantee that an abusive party was not listening into a teleconsultation. It was suggested this may be particularly concerning for women from minority ethnic cultures who may be pressured into seeking a sex-selective abortion. Further, it was suggested that self-administration of abortion medication removes any control over who takes the pills, where they are taken, whether they are taken, when they are taken (both in terms of gestation and the administration requirements of the medication), or if an additional adult is present for support. Respondents felt that in-person services provided a substantial safeguard against this mismanagement, and so should not be bypassed;
- Risks to women's physical health - respondents highlighted that various doctors, NHS staff, Government departments, Ministers and spokespeople had raised concerns about the possible physical complications linked to EMAH, and outlined their concerns and/or instances which included significant pain and bleeding, haemorrhage, rupture of the uterus, ruptured ectopics, sepsis, resuscitation for major haemorrhage, endometritis and toxic shock syndrome associated with Clostridium sordellii, and death.

[14] https://www.worldcat.org/title/nonverbal-communication/oclc/752953369

[15] https://www.themdu.com/press-centre/press-releases/majority-of-gps-plan-to-continue-with-remote-consultations-and-triage-post-covid-19-mdu-survey

Respondents also identified a study from Finland which suggested that the rate of complications was four times higher in medical than surgical abortions (it should be noted that this was, however, not based on Scottish data[16]). In relation to ectopic pregnancies, they highlighted that it was possible to have an asymptomatic ectopic pregnancy and therefore ultrasound scanning should be standard practice before EMA (which would also assist in verifying gestational date). It was also claimed that some women who are Rhesus D negative may not receive prophylactic Anti-D, which could result in isoimmunisation in future pregnancies, where the mother produces antibodies that harm the developing fetus' blood cells[17].

- Risks to women's mental health - it was proposed that many women may be unsure of their decision, may be being coerced into the abortion, may not fully understand the potential distress caused by the procedure, and, in order to avoid these potential issues, require more in-depth face-to-face psychological support than possible during a teleconsultation. Respondents advised that research had suggested that mifepristone may have direct pharmacologic effects that increase risk of mental health issues as it releases inflammatory cytokines that have been implicated in causing depression. Testimonials were provided from two women outlining their perceived psychological trauma of the procedure. Further, respondents suggested that it was not in the commercial interests of service providers to offer time and space for psychological support, and they felt that entrusting the mental health of women to the providers who "financially benefit from abortion" seemed irresponsible.

Ultimately, respondents felt that the best way to mitigate these risks was to immediately withdraw the temporary provision of EMAH, and require an in-person consultation prior to women receiving a medical abortion.

As at Q1a, numerous references were provided to support the arguments being offered. Sources included UK Government studies, journal articles, news reports, elements of the Abortion Act 1967, and abortion providers and NHS Inform Scotland websites and guidelines.

Q4. Views on the potential impacts of continuing the current arrangements for EMAH on equalities groups?

In response to the quantitative element of this question, respondents stated 'yes'.

Respondents discussed impacts on various groups, including:

- Pregnant women;

[16] For example see NICE guidelines – decision aids for patients- abortion-before-14-weeks-choosing-between-medical-or-surgical-abortion-patient-decision-aid-pdf-6906582255 (nice.org.uk)

[17] As noted previously, NICE guidelines already recommend that Anti-D is not required for medical abortions where women are under 10 weeks gestation. SACP guidelines also recommended that once Covid-19 is no longer considered a significant risk, women between 10 and 11+6 weeks should again be given Anti-D where appropriate.

- The embryo or fetus (referred to as ‘unborn children’ by respondents);
- People with disabilities; and
- Conscientious objectors within the medical profession.

Impact on pregnant women - respondents felt that EMAH presented great risks to women’s physical and mental health. They argued that removing face-to-face consultations would negatively impact the consultation experience and decision-making process of women who would otherwise rely on in-person communication due to impaired hearing or vision, as well as those suffering debilitating mental health conditions and those exposed to coercion. They also noted that pregnant women were more likely to suffer from domestic abuse, and suggested that EMAH provided abusers with easier access to abortion medication, and placed pregnant women at risk.

Impact on ‘unborn children’ - respondents stressed that the fact the fetus up to 12 weeks gestation was not recognised as a protected age category or equality group in the consultation was extremely concerning. They felt it was important to highlight the impact that continuing EMAH would have on the rights of ‘unborn children’. They noted that last year the second highest number of abortions were recorded in Scotland since the Regulations were introduced, and that data showed abortions were continuing to rise and are at an all-time high in England and Wales. They considered this to be “a grave healthcare failing for the UK that denies the right to life of unborn children as a protected equality group”.

Impact on medical professionals with religious affiliations - It was suggested that EMAH may negatively impact medical professionals who hold religious beliefs which would prevent them from facilitating an abortion procedure. It was noted that the Abortion Act 1967 ensured conscientious objection rights for any medical professionals engaged in direct participation. The respondents believed it was unclear what would be considered ‘direct participation’ for those supporting the provision of EMAH. For example, would someone be able to opt-out of being required to post abortion medication to a woman’s home? Respondents stressed that clarity around this was urgently needed.

Q5. Views on potential impacts of continuing the current arrangements for EMAH on socio-economic equality?

In response to the quantitative element of this question, respondents stated ‘yes’.

The respondents noted that, again, consideration was only being granted to the born rather than the unborn. They also suggested that equal access to what they perceived to be a dangerous process was the wrong measurement of success.

They believed that EMAH may increase inequality in health outcomes experienced by socio-economically disadvantaged groups, including homeless women. Firstly these socio-economically disadvantaged groups may face problems in accessing technology or with not having a fixed postal address, and secondly it was believed that opportunities may be missed to pick up on health issues in those who are not engaging with routine GP check-ups.

They suggested that women living in poverty or concerned about falling into poverty may be more likely to seek abortion. Respondents reported that abortion rates were more than two times higher in the most economically deprived areas in Scotland than the least deprived. This cited statistic was considered to imply that women in poorer areas were more at risk from EMAH (referenced in the standard response as unsafe 'DIY' home abortions) under the current arrangements.

As such, they felt that in-person assessments should be mandatory for all women, especially those in vulnerable socio-economic circumstances and those lacking technological access and aptitude, who they suggested were disproportionately vulnerable to the dangers of EMAH.

Q6. Views on potential impacts of continuing the current arrangements for EMAH on women living in rural or island communities?

In response to the quantitative element of this question, respondents stated 'yes'.

Respondents felt that pregnant women living in rural and island areas with limited access to healthcare were greatly disadvantaged by EMAH, due to the risk of serious complications. It was noted that the population of rural Scotland faced particular challenges in terms of access to key services, including hospital outpatient services.

While they felt the risks had been shown to be great for all women, they considered they were potentially greater in rural and island areas. One example offered was if a woman had underestimated the gestational date and suffered complications, it would be much harder for her to gain rapid access to emergency services. As such, they felt that women should be required to attend a clinic for the EMA, and that this would be especially vital for those living in rural or island communities who may not have immediate medical assistance available should they suffer from serious complications. They suggested that prolonging the EMAH arrangements for women in these areas reinforced the health access divide between urban and rural populations.

Ultimately, they argued that face-to-face consultation should be compulsory for those living in rural or island communities, given the perceived advantage they reported in communication and care over EMAH.

Q7. How should early medical abortion be provided in future, when COVID-19 is no longer a significant risk?

In response to the quantitative element of this question, respondents stated 'Option b - Previous arrangements should be reinstated - in other words women would be required to take mifepristone in a clinic, but could still take misoprostol at home where this is clinically appropriate'.

Respondents felt the previous arrangements should be reinstated, at the very least. Preferably, however, both mifepristone and misoprostol should be taken in a clinic, to ensure they are taken properly, at the appropriate time and in the correct manner.

Perceived challenges related to the current arrangements were outlined. These challenges included women being responsible for managing the 'standard dosing interval' and other aspects of self-administration, identifying and supervising their own 'symptoms of significant anaemia' along with any other side-effects or complications, the inability to verify an accurate gestational date which may result in a patient applying misoprostol in a manner unrecommended for their health, and the lack of verified gestation date would also hinder a patient's capacity to make a fully informed decision concerning the risks of different methods for applying misoprostol at home.

They suggested that taking both pills in a clinic would provide an added measure of safety so that, should the patient experience a complication, medical care would be immediately accessible. It was proposed weight for this argument was given by the Scottish Abortion Care Providers guidelines previously advising the patient has another adult present when undertaking EMAH[18], with the respondents arguing that appropriate medical support would be the optimal management.

Respondents also suggested that the options presented had not met the 'validated impact assessments' advised by principle C of the UK Government's Consultation guidelines. They note that no evidence was given to explain concerns identified in the consultation document (e.g. risks due to not having an appointment in person such as the difficulties of judging gestational date or establishing the presence of coercion), and concluded that these concerns were reason enough to prohibit EMAH. Given the absence of critical information concerning the problems introduced by the implementation of EMAH they felt that this question could not be fairly answered by any respondent relying upon the consultation paper for evidence of the impacts of the competing options. With access to wider research, they felt that both forms of abortion (both the current arrangements and previous arrangements) posed serious risks to women, as well as 'resulting in the death of an unborn human being'.

[18] It should be noted, however, that the guidelines have since been updated and now state that it is optional for women to have someone with them.

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-80004-856-0 (web only)

Published by The Scottish Government, June 2021

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS847106 (06/21)

w w w . g o v . s c o t