Foreword

FOREWORD BY DAME CLARE GERADA

It is my personal feeling that women have no more rights regarding their bodies and healthcare than when I was born 62 years ago. As a GP of over 40 years, I have treated thousands of women. However, throughout the process of crafting this report, I have been shocked to learn that many of the medical interventions and procedures held up by institutions and policymakers are not in place for the good of women's health but serve to prevent women from being in control of their own bodies.

Health systems are infantilising women, deeming them incapable of looking after their own health, without the state interfering at every stage. Whether that is by demanding attendance at a clinic to obtain contraception or through insisting that women are assessed for psychiatric illness if they request an abortion. Women are constantly told throughout pregnancy what they can and can't do, so it is no wonder that so many pregnant women have been hesitant to take up the Covid-19 vaccine. It is now a devastating reality that a huge number of patients suffering with the virus in ICU are expectant mothers. The total policing of women's bodies by the systems and structures that are set up to look after them has resulted in a situation where women don't trust themselves or their instincts, about their own health.

We have gathered both women and men from all over the world together to discuss why it is that women remain isolated from the services and medical interventions they need. These problems cannot be fixed overnight but gathering to discuss the solutions is a step in the right direction. Women account for over 70 per cent of the global health workforce and make up 50 per cent of the global population.[1] If enough of us keep talking, the world must start listening.

Foreword

FOREWORD BY DAME LESLEY REGAN

Across the span of my career as a gynaecologist I have had the privilege and opportunity to provide advice and care for women across their life course. It is vital to understand that women's health extends far beyond reproduction; the wellbeing of the woman sitting in front of me has been largely determined by the ability to make informed decisions about her own health. Empowering women with the tools and information needed to make personal choices is key to enabling her to achieve better long-term health outcomes for herself.

This report considers the global needs of women in the 21st century, which has brought us the largest generation of adolescent girls in history, treatments that can circumvent infertility, increasing complexities during pregnancy in older women, the first ever generation of women whose improved life expectancy will dictate that they spend longer as a menopausal woman than they had reproductive years. Across the world, women's respective health systems are failing to cater to their needs and many of their most important issues remain shrouded in taboo. We must seize every opportunity to advocate for women so that they can become ambassadors for each other, understanding where their respective healthcare

systems may be falling short and what they should do to access the advice and practical help they need.

The many individuals we invited to contribute to the evidence gathering and debate under pinning this report, confirmed how the very same issues are being experienced by women across the globe. It is clear that cross systems leadership and accountability are required to deliver improved health services for women.

Women's health outcomes impact not only the individual woman and her family, but the healthy functioning of society as a whole. We must ensure that women's health holds a place at the top of the healthcare and wider political agenda. Every one of us has a part to play in achieving this goal.

Recommendations

CONTRACEPTION

Sexual and reproductive health services must be prioritised to counter patchy healthcare service provision – and access must be made available, in and out of hours.

NICE should re-examine guidelines that recommend routine appointments for oral contraception users – with a view to limiting unnecessary medical checks that may only serve to limit contraception access.

Progestogen-only pill (POP) should be made available on general sales (off the shelf) and not require consultation with a pharmacist unless the woman wishes.

Those who plan and purchase healthcare must ensure provision of full range of contraception services to all women that is person centric and at all reproductive ages, with a particular focus on targeting women of low socioeconomic status (SES) and minority ethnic women. This should include ensuring emergency hormonal contraception is free in 100 per cent of healthcare service provision.

While Long Acting Reversible Contraception (LARC) should be encouraged, the greatest impact for reducing unplanned pregnancies must focus on influencing women who use no contraception to begin using any form of reliable contraception.

Post birth contraception must become an integrated part of maternity services and funded appropriately. Women should be routinely offered a choice of contraception post delivery and given information about the importance of birth spacing to improve their health and that of their baby/family.

ABORTION

To further increase access to telemedicine abortion, health providers should enable a greater number of staff to undertake telemedicine abortion and prescribe the medications – this should include enabling training nurses and pharmacists to undertake the clinical consultation.

Post-abortion care can be self-managed by the woman and this should be advocated for within local sexual and reproductive health services.

Access to telemedicine should be enhanced and obstacles to access removed wherever possible. This should include removing the need for women to have a routine scan within a clinical setting in order to qualify for a telemedicine abortion.

Abortion should become further integrated with contraception services and wider sexual and reproductive health service provision. Health providers should ensure that contraception is offered at the time of abortion if desired by the woman.

Introduction

This report highlights the importance of embracing a culture of change in the design and delivery of women's health to achieve national systems and local services fit to meet the expectations and needs of the 21st century woman. It describes the many failings of health services across the world whose default position is to treat women as second-class citizens and place unnecessary barriers to the delivery of high-quality accessible care. Over the course of writing this report, discussions have been held with men, women, and girls from across the world. These conversations have shown that women are rarely trusted to be masters of their own bodies, but instead are frequently subjected to paternalistic and overly medicalised interventions.

The recommendations of this report are founded on common sense and rooted in the belief that women should be in control of their own bodies. They are the direct outcome of the concerns, suggestions and ideas generated by people we have brought together from across the world, who are determined to make their environments healthier and fairer for all.

The United Nations Sustainable Development Goals (SDGs) 2016–2030 represent a set of targets for countries across the world, designed to end poverty, protect the planet, and ensure prosperity for all. Two of the 17 SDG goals explicitly recognise the importance of girls and women, and their health, to achieving this ambitious aim.

SDG 3: to "ensure healthy lives and promote wellbeing for all at all ages", includes a commitment to "reduce the global maternal mortality ratio to less than 70 per 100,000 live births", and to "ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes."

SDG 5: to "Achieve gender equality and empower all girls and women", again underlines the importance of sexual and reproductive health, while also including commitments to "eliminate all forms of violence against women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation" and "eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation." Unlike its predecessor Millennium Development Goal 3, SDG-5 calls on governments to achieve, rather than just promote, gender equality and the empowerment of all girls.

This report builds upon the Royal College of Obstetricians and Gynaecologists (RCOG) 2019 publication *Better for Women*, which made 23 clear recommendations to policymakers on how to improve the health of women and girls. However, the primary aim was to encourage the creation of national strategies for women's health based on a life course approach. The emphasis was on placing women at the centre of preventative health services which are designed to address their many predictable areas of need.

The UK government's women's health strategy, due to be published in Spring 2022, offers the unique opportunity to see the evidence-based recommendations from *Better for Women* and this report, *A Women's Health Agenda* be brought to fruition.

The chapter topics of this report were selected because of the important contributions they make to women's daily lives and because historically these issues have been shrouded in taboo and stigma, frequently leading to polarised opinions and viewpoints. They also provide opportunities to redress the balance by adopting practical solutions which redirect valuable resources to the areas of greatest need and reduce barriers to achieving measurable improvements in:

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- Contraception
- Abortion
- Assisted conception
- Menstruation and Menopause
- Breast Cancer
- Cervical Cancer
- A Gendered Lens: Data, Research and Policy

The subjects covered within this report are by no means exhaustive nor are they representative of every woman across the world. However, this document makes a significant contribution to the growing body of evidence which demonstrates that women's health has been disproportionately disadvantaged globally. It also draws attention to the fact that equitable health systems are more cost-effective and efficient, because healthy women are the cornerstone of healthy societies.[4]

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in women living in disadvantaged areas with lower educational achievement and poor dietary intake.[9] As such, they are less likely to follow infant feeding advice and the cycle of poor

health is transmitted to the next generation. Similarly, it is well recognised that intervals of 18 – 24 months between births affords both mother and baby significantly improved outcomes. This highlights the importance of not missing the opportunity to provide a range of contraceptive options to women immediately after delivery, compatible with breastfeeding, to avoid short intervals between pregnancies.

As noted earlier, SDG-3 stresses the importance of universal access to contraception in addressing inequalities and achieving health equity worldwide.[10] However, numerous barriers preventing women from accessing and benefiting from reliable contraception remain, many of which result from outdated health systems and the continuing paternalistic views of many health care professionals.

The UK's policies on contraception have been, until recent years, progressive. In 1967, contraception was made available regardless of marital status and by 1974, 1000 NHS family planning clinics were established to make contraception free and more accessible to all.

Emergency hormonal contraception (EHC) has been available since 1984 and was refined by introducing progestogen-only EHC as a pharmacy medicine.[11] Between 1999 and 2010 the national strategy to improve sexual health and reduce teenage pregnancy rates achieved an impressive 51 per cent fall in under 18-year-old pregnancies.[12]

Since 2005, long-acting reversible contraception (LARC) methods (intrauterine devices, implants, and injections) have been recommended by the National Institute of Health and Care Excellence (NICE). More clinically effective than pills or barrier methods, LARCs are also highly cost effective - even if the duration of use is for one year or less.

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Demographic trends: Increasing demand and declining provision

Shifting global demographics and changes in social expectations are increasing demand for contraceptive services. A falling birth rate, smaller families and increase in childlessness has resulted in longer intervals during which pregnancy needs preventing. In the UK, one in five women now remain childless and the interval between first sexual relationship and first pregnancy has also lengthened, with an average of 13 years in which contraception is needed before a woman's first birth.[13]

Following the Health and Social Care Act (HSCA) of 2012, sexual and reproductive health (SRH) services in England have been subject to serious disruption due to financial cuts in public health budgets and fragmented commissioning. The transfer of family planning services to local authorities created patchy service provision and by 2020, 54 per cent of all clinics had closed and the Family Planning Association went bankrupt.[14]

Commissioning and governance of SRH services was split between three separate organisations, which created a postcode lottery for users, siloed working and a lack of accountability and ownership. The impact of this disruption was evidenced by a fall in the

use of emergency contraception and a sharp increase in abortion rates, predominantly in older women who had completed their families and were unable to access LARCs. From 2016 to 2020, the number of abortions rose from 190,000 to over 210,000 per year in England and Wales.[15] This situation was further exacerbated by the onset of the Covid-19 pandemic in 2020 which led to a fall in contraceptive service access generally and LARC usage plummet, resulting in a sharp increase in complex maternities and abortion requests after very short birth intervals. It is worrying that, as we emerge from the pandemic, the UK has cut its pledge to the UN family planning programme by 85 per cent.[16]

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Global patterns of contraceptive use still favour user dependent methods such as male and female condoms, diaphragms and caps, spermicides and digital tools supporting natural family planning, all of which are significantly less effective than hormonal methods. Oral contraceptive pills (OCP) are the most used form of contraception and are simple to take - as a daily pill – but are still user dependant. OCPs and barrier methods still dominate over the use of LARC which are the most reliable and cost-effective method. The percentage of women of reproductive age using LARCs is estimated to be 14 per cent, mainly due to a shortage of health care professionals trained to fit implants and uterine devices.[17]

The combined COCP, containing both oestrogen and progestogen has been available for over 60 years and has been extensively researched. However, in the UK it is still only available on prescription from a medical practitioner, which serves as a barrier to both starting and continuing use. The progestogen only pill (POP) has fewer contraindications and associated health risks and third generation preparations that inhibit ovulation are as effective as COCPs. The POP was reclassified as an over the counter (OTC) medication in July 2021, which is a welcome development and could potentially pave the way to relaxing regulations for other contraceptive options.

Simple solutions to cut the red tape

The need for contraception does not require a diagnosis to be made since these women are not ill and do not have a disease requiring regular monitoring. They simply need a reliable method to control their fertility and avoid or postpone becoming pregnant. There are simple solutions to removing many of the barriers women face when trying to access contraceptive services. Family planning strategies have tended to focus on younger women (under 20-year-olds), since these pregnancies are more likely to be unplanned. However, the reality is that 77 per cent of pregnancies in women over 40 are unplanned, a group who are likely juggling work, childcare, and other family commitments.[18]

Recommendation: Sexual and reproductive health services must be prioritised to counter patchy healthcare service provision – and access must be made available, in and out of hours.

Despite a 60-year safety record, women are still likely to be given a three-month prescription for any form of OCPs and are told to make an appointment for a medical check-up to renew their prescriptions. Indeed, 50 per cent of all contraception appointments are for repeat

prescriptions imposing unnecessary pressure on services. It is important to recognise that even for women with significant medical problems, such as raised blood pressure or poorly controlled diabetes, it is far safer to avoid an unplanned pregnancy than have a minor complication from taking their COCP.

Recommendation: NICE should re-examine guidelines that recommend routine appointments for oral contraception users – with a view to limiting unnecessary medical checks that may only serve to limit contraception access.

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empowered to remove such appointments, it may lead to increased contraception uptake among women and girls.

Despite being made available over the counter in pharmacies from July 2021, women still have to consult with a pharmacist to obtain the POP. If provided over the counter, the POP is not free of charge, unlike if the same medication was obtained via an NHS prescription. This raises inequalities of access and places disadvantaged women with limited income or difficulties accessing the health system at unnecessary risk of an unplanned pregnancy.

Recommendation: POPs should be made available on general sales (off the shelf) and not require consultation with a pharmacist unless the woman wishes.

> "There is a reported six-fold difference in teenage conception and birth rates between the poorest areas in England and the most affluent areas"

Recommendation: Those who plan and purchase healthcare must ensure provision of full range of contraception services to all women that is person centric and at all reproductive ages, with a particular focus on targeting women of low SES and minority ethnic women. This should include ensuring emergency hormonal contraception is free in 100 per cent of healthcare service provision.

LARCs are the most reliable and cost-effective methods of contraception and do not require renewal for three to five years. There are many missed opportunities for GPs, midwives, specialist nurses and gynaecologists to provide women with LARCs due to funding to provide training and fees for the provision of injectables, implants and IUD insertions not being prioritised.

LARC methods of contraception should be encouraged, but not to the exclusion of women being able to use any reliable form of contraception. Research has shown that a woman's decision as to what form of contraception she uses has less impact than her decision to use contraception in the first instance.[24] This means that efforts need to be focused on encouraging behaviour change of sexually active women who do not use birth control to use any reliable contraceptive method, if they do not want to become pregnant.

Recommendation: While LARC should be encouraged, the greatest impact for reducing unplanned pregnancies must focus on influencing women who use no contraception to begin using any form of reliable contraception.

The immediate post-delivery (postpartum) period is another opportunity to provide women with reliable contraception. Ideally, discussing family planning options should begin during the antenatal journey and be offered again soon after birth, so that all women can be provided with a long-acting method which is compatible with breast feeding, before they leave the health facility. Since the midwife plays the key role in continuity of care in maternity services, she is best placed to provide post-delivery contraception. However, the *State of the World's Midwifery 2021 report* points out the shortage of midwives globally and estimates a shortfall of 900,000 midwives across the world. While midwives make up less than 10 per cent of the Sexual, Reproductive, Maternal, Newborn and Adolescent Health (SRMNAH) workforce, they could provide 90 per cent of essential SRMNAH interventions across the life course.[25]

Enabling a greater contribution by midwives in providing family planning services (especially LARC), has been a major factor in increasing the contraceptive prevalence rate in some middle and low-income countries. A study conducted in Nigeria has demonstrated that the contraceptive uptake rate has doubled in less than five years because of midwifery led contraceptive services.[26]

Enabling midwives to provide contraceptive care, by designing e-learning tools and practical sessions to master LARC insertion requires protected time for training, upskilling and continued professional development. Rather than contraceptive services being viewed as an additional task for midwives to undertake, it should be considered an extension of their current role and an opportunity for career development which provides them with further autonomy in delivering maternity care. Better

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Enabling midwives to provide contraceptive care, by designing e-learning tools and practical sessions to master LARC insertion requires protected time for training, upskilling and continued professional development. Rather than contraceptive services being viewed as an additional task for midwives to undertake, it should be considered an extension of their current role and an opportunity for career development which provides them with further autonomy in delivering maternity care. Better links between midwifery and specialist sexual and reproductive health services need to be encouraged.

CASE STUDY

UNFPA: The Family Health House Model

As sited from the Mid-Term Review, the Family Health House Model is a piloted model funded through the United Nations Population Fund (UNFPA) and aims to improve the access to reproductive and child health services in underserved districts. Through the implementation of mobile support teams, containing trained healthcare staff, the aim is to reduce morbidity and mortality, as well as improving quality of life. This coincides with UNFPA global strategy to enhance women's rights and empowerment, especially within these deeply deprived locations.

An outline of services

- Each Family Health House, known as the Ashiana-e-Sehi, covers a population of 1,500-3,000 and holds a trained midwife and effective referral system to Basic Package of Health Services (BPHS) facilities

- Health posts connect the members of the community to the Family Health Houses through provision of more basic health services

- Family Health Action Groups contain a handful of female volunteers that promote good healthcare within their communities, as well as encouraging others to use the Family Health House

- As well as female volunteers, each community develops a Health Shura. This is an assemble of leaders and spokespeople that delivery public health procedures and enforce guidelines

From the outlined project, 95 per cent of community midwives that completed their community midwifery education remain within their communities. Although there is more work to be done to reduce the political impacts on women's health and liberties, the Family Health House Model reflects how crucial communities are within improving national healthcare systems. Not only does it encourage further education for women through the midwifery training, but it also provides services to rural areas that would have been unable to reach them previously.

MARIE STOPES KENYA: IMPROVING ACCESS TO CONTRACEPTION FOR UNDERSERVED WOMEN IN KENYA

Marie Stopes Kenya (MSK) is a leading specialized Sexual and Reproductive Health (SRH) and Family Planning (FP) organization in Kenya and aims at expanding healthcare equity focusing on increasing access to and uptake of SRH/FP services among the underserved populations including youth, people with disability, rural populations, and the urban poor.

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The problem

According to a MSK client exist survey in 2020, 63 per cent of high impact clients don't have access to modern contraceptive and post abortion care (PAC) services at government public facilities. The high impact clients at MSK include:

- Women living on less than $1.25 per day
- FP Adopters
- Clients under 20 years of age
- Those who would not otherwise have access to FP

The solution

MSK has crafted a model called Public Sector Strengthening (PSS) with the aim of providing affordable and quality assured FP and PAC services to high impact clients by strengthening the health system.

PSS can be implemented across each of the four high impact clients outlined.

- Women on less than $1.25 per day: To ensure lower income earners can access SRH services, PSS services should be free, unless government regulations require otherwise. By giving couples the choice over their fertility, they can better care for their children to help break out of the cycle of poverty
- Adopters: By targeting clients not currently using modern contraception, this can help to reach the MSI goal: to ensure one in four women have their demand for contraception met by 2030. Providing first time users with a quality client experience at PSS sites will encourage them to continue to use FP, and potentially become advocates within their community
- Adolescents: For those under 20 years of age, there is a considerable unmet need for SRH services, particularly in the rural areas. As such, PSS has a key role to play in reducing this unmet need
- Those without access to FP: PSS adds access points for those in need of family planning, by training staff who would otherwise not have been able to offer these

services

Reported via internal data sourcing, MSK has helped to increase the use of Long-Acting Reversible Contraception (LARC) from 27 per cent in 2020 to 33 per cent in 2021 among women served in public health facilities. This shift to long-acting methods is likely to reduced discontinuation rates and may better meet women's needs in the public health facilities in Kenya.

POST-DELIVERY CONTRACEPTION: IMPERIAL LOCAL MATERNITY SYSTEM PILOT

Following the first UK Covid-19 lockdown in March 2020, it quickly became evident that women were unable to access contraception from their GP or community clinics after leaving the maternity facility. Women can become pregnant again within 21 days of delivery and 50 per cent of couples resume sex within six weeks of delivery. Women who are breastfeeding or have absent periods are poorly protected from conceiving again and short interpregnancy intervals (<12 months) are associated with serious obstetric complications. Since sexual and reproductive health commissioning is not integrated with maternity services, 29,000 women per year in North West London have no access to reliable contraception.

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after delivery. The escalating costs of this oversight has been estimated at £1.6 million a year for North West London alone, despite the knowledge that the overall return on investment (ROI) for post-birth contraception is £16 for every £1 spent.

Since 2020, a collaborative team of midwives, obstetricians, sexual and reproductive health colleagues and commissioners have built a post-delivery contraception service by developing theoretical and practical courses for all midwives and doctors to be trained in contraception counselling and LARC fitting. All pregnant women are provided with antenatal counselling and a range of breastfeeding friendly contraception, including the progesterone-only pill, sub-dermal implants and if delivering by caesarean section, copper or levonorgestrel intra-uterine devices.

This North West London service serves as an exemplar for other regions in England to adopt and benefit from this learning curve by using similar models of care. This post birth contraception model should be rolled out nationally to assist in the levelling up required in the aftermath of the Covid-19 pandemic. Contraception plays an essential role in the health and wellbeing of women everywhere. This innovative pilot programme has demonstrated that providing new mothers with a choice of contraception including LARCs, immediately post-delivery, is highly cost-effective, protects NHS resources and is popular with women.

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Chapter Two

ABORTION

Introduction

Abortion is one of the most common procedures that women of reproductive age undergo. Globally the total number of pregnancies is in the order of 215 million per year, of which 73 million end in abortion. This equates to over one in four pregnancies or 150,000 cases of abortion per day. Nearly half of these abortions are unsafe, with complications usually developing when they are performed by untrained individuals, in unsuitable locations or via medications bought illegally. Of these unsafe abortions, 97 per cent occur in areas of Africa, Asia, and Latin America, where restrictive abortion laws lead to unsafe abortions and maternal deaths. Unsafe abortions are sought by an estimated three million adolescent girls every year, who have no access to contraception.

Abortion accounts for 14 per cent of the global total of 303,000 maternal deaths which occur every year, which is eight women in the world dying from abortion every hour. The figure of 14 per cent is the same as the mortality in the UK from unsafe 'backstreet' abortions prior to the introduction of the 1967 Abortion Act. Nevertheless, it took several years following the act for mortality from abortion in the UK to reach zero for the first time. To this day, abortion remains the only procedure in UK medicine requiring two medical doctors' signatures on the consent form – which is still a criminal offence if not adhered to.

More than any other women's health issue, societal attitudes towards abortion are polarised. However, laws impact heavily on whether abortions result in serious health effects. Legal restrictions have little effect on the number of girls and women seeking an abortion, but they have a major effect on the outcome of that abortion in the health of the girl or woman.

Where abortions are carried out in countries with few or no legal restrictions, around 99.9 per cent are completed without any serious complications. This contrasts with only 25 per cent in countries where it is illegal or where the woman must pass through barriers to obtain the procedure. Restricting access to abortion does not reduce the number of abortions, indeed the opposite is true, since the provision of abortion and contraceptive services are invariably linked. Banning abortion does not make the problem disappear it simply moves underground and becomes unsafe, leading to maternal deaths and life altering morbidities.

Countries with more progressive attitudes towards women generally have more liberal abortion laws. Nevertheless, recent world events have revealed little room for complacency and that attitudes and access to safe abortion can change rapidly. During the Covid-19 pandemic, for instance, elective abortions were banned in six European countries and suspended in one.[40] Meanwhile, in the USA where women have a constitutional right to have an abortion, numerous individual states have used Covid-19 as an excuse to ban all forms of abortion, by classifying abortion as non-essential healthcare.[41]

The Guttmacher Institute, a leading research and policy institution which is committed to advancing sexual and reproductive rights, made a prediction in April 2020 of the potential impact that Covid-19 would have on women's SRH services in 132 low-to-middle-income countries (LMICs). They suggested that a 10 per cent disruption in essential SRH care (both the use of short and long-acting contraception and a shift in abortions from safe to unsafe) would result in a massive increase in the number of unintended pregnancies (15.5 million) unsafe abortions.

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(3.3 million) and maternal deaths (10,000). Recent data from Guttmacher suggest that this prediction may have been an underestimate and that the year 2021 will be remembered as "the most devastating anti-abortion year in history."[42]

The World Health Organisation (WHO) asserts that there is a clear and unambiguous right to normalise abortion as a public health right.[43] Human rights frameworks are the most effective vehicles in which to push for less restrictive abortion laws. All abortion procedures should be subject to regulatory and professional standards, in line with other medical procedures, rather than to criminal sanctions.

The introduction of telemedicine abortion

Women in England and Wales can have an early medical abortion (EMA) before the end of the 9th week of pregnancy, within a legally approved setting. In Scotland the gestational limit is less than 13 weeks. EMA involves taking two drugs, mifepristone, followed 24–48 hours later by misoprostol. Women used to be required to attend the clinical setting on two separate occasions to take their medications in the presence of the supervising health professional. This requirement was despite good evidence that there was no need for these drugs to involve face to face meetings. In 2018, it was agreed in England that women could be allowed to take the second drug misoprostol in their homes in the same way that this would be managed for an incomplete miscarriage.

Protecting NHS resources and reducing Covid-19 transmission was the catalyst for the necessary legal orders to be agreed (on a temporary basis), for both EMA drugs to be provided at home following a structured remote (telephone or video) consultation. Telemedicine early medical abortion (TM-EMA) can now be provided at home following the remote consultation with the medicines administered to the patient from a pharmacist who dispenses the prescription provided by the qualified abortion care provider.

Telemedicine abortion is proven to be safe, effective and is preferred by women. Studies from across the world demonstrate that being able to take the abortion drugs at home is far more convenient for women. In Norway, 95 per cent of women opted to have an abortion at home, citing, 'greater privacy', 'more control' and 'better emotional support'.[44] The method has been recommended for years by WHO, NICE and RCOG, Faculty of Sexual and Reproductive Health (FSRH) – all of whom have published clinical guidelines to aid health professionals provide safe, compassionate, high-quality care.

In the UK, the swift introduction of TM-EMA during the first wave of the pandemic in spring 2020 was extremely successful. The average waiting time for treatment was halved, resulting in the gestation at the time of the procedure falling by more than a week, thereby reducing the rate of complications which increase incrementally with each passing week of pregnancy.[44] Together these factors have meant that the need for late gestational abortions has fallen and removed additional strain on surgical services during the pandemic. Only a very small number of women require a scan or clinical examination due to uncertainty about the date of their last menstrual period or other potential complicating factors. There has been

no increase in undiagnosed ectopic pregnancies and the overall rate of abortion success has increased.[46]

There is no clinical reason for a woman to need to attend a clinic for a routine follow up after an abortion. Instead, advice should be provided so that she understands when, how and why she might need to seek medical attention. The outcome of an early medical abortion can be self-assessed at home, with low sensitivity pregnancy tests being suitable for use.

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> "There is no clinical reason for a woman to need to attend a clinic for a routine follow up after an abortion"

The implications of telemedicine abortion for women are significant. Patient satisfaction rates with the service are high, exceeding 83 per cent.[47] Women can receive this healthcare in the comfort of their own home, providing them with privacy and obviating the need to make long journeys, take time off work and arrange childcare. For women in vulnerable situations, safeguarding has improved since women no longer have to risk being seen entering a clinic and can communicate with the trained provider confidentially. Furthermore, the illicit sourcing of abortion drugs from the internet has melted away and cost savings for the health service associated with the TM model of care.[48] [49]

Currently in the UK, only a fully trained abortion provider (usually a doctor) can administer telemedicine abortion. Global data demonstrates that TM-EMA can be safely delivered by appropriately trained health care providers such as nurses, midwives or pharmacists and it is hoped this would be the next logical step to long term improvements in abortion care.

Despite the unprecedented success of telemedicine abortion during the pandemic, in February 2022, the UK government made the decision to scrap the scheme by the end of September 2022. While being kept under review, this decision was criticised by several senior organisations including the Royal College of Obstetricians and Gynaecologists, the British Medical Association and the Royal College of Midwives.

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The Problems

- **The over-medicalisation of abortion, and ineffective use of resources.**
  There is no clinical reason why everyone seeking an abortion must have a scan. This is a poor use of pressurised resources, an unnecessary intrusion, and within the UK context, an addition to already lengthy NHS waiting times.

- **The access barriers, especially for the most marginalised.**
  There are people who need or want an abortion but cannot safely or easily get to a clinic in person, such as disabled women, women in abusive relationships, and young girls living with abusive families. Consequently, safe, legal abortion services

become inaccessible to those who need them most urgently, resulting in people ordering unregulated medicines online.

- **The lack of privacy and dignity.**
  Visiting an abortion clinic can be a stressful experience, with anti-abortion groups circulating outside some clinics. This is not only intimidating and guilt-provoking but can also be retraumatising for women that have experienced sexual violence or domestic abuse.

THE BENEFITS OF TELEMEDICINE

Telemedicine offers a solution to each one of these problems and is one of the many pandemic-resilient services that should remain available henceforth. It removes the barriers for those unable to travel to a clinic and allows clients to start on the MSI pathway once deemed clinically appropriate by a fully trained health advisor. This would allow them to end their pregnancy safely at home, in a more private and dignified setting. Ultimately, telemedicine gives women control. The limited procedures that prevented women having autonomy and respect have been appropriately modernised, and these should be kept available for future generations.

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> “Studies show that women value the opportunity to discuss contraception during a pre-abortion assessment”

...have given birth within a year of having an abortion.[54] Several randomised trials have demonstrated that providing contraception at this time significantly lowers the risk of another unintended pregnancy or short birth interval, thereby reducing future pregnancy complications.[55] If the desired form of contraception cannot be administered immediately, ‘bridging’ methods should be discussed and preferably provided in the home termination pack or arrangements made for the woman to have a consultation. Bridging contraception refers to contraceptive methods that can be started immediately and used until the desired form of contraception can be made available to the user. Condoms, pills and injectables are all useful bridging methods. The latest injectable subcutaneous preparations can be self-administered monthly, using prefilled syringes, and have proven to be an extremely popular option for women.

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BRITISH PREGNANCY ADVISORY SERVICE (BPAS) PILLS BY POST

The Covid-19 pandemic resulted in women unable to leave their house to access care and, with a third of BPAS clinics closed by 23rd March 2020, many urgent treatments were delayed. Immediate action was needed to restore women’s autonomy, so in March 2020 BPAS led the campaign to provide evidence-based requests for telemedical abortion provisions to be implemented. Within nine days of the law being changed, Pills by Post

(PBP) was launched which allowed midwives and nurses to hold virtual consultations and post medication to a woman's home address when suitable. These packages contained both mifepristone, to break down the uterine lining, and misoprostol, to expel the pregnancy tissues.

Promotional materials were acceptable to pharmacy staff, for service users, the notion of calling a stranger on a hotline to speak about the sensitive issue was considered culturally unusual. As a result, MSI and partners developed and tested different means of communicating information directly to medical abortion users, such as user-friendly product labelling, signposting users to contact centres, and by working with national health legislature to ensure pharmacy staff and medical abortion users have access to high quality information.

The key takeaway is the importance of building up an appropriate, multi-format information infrastructure for medical abortion users to safely manage medical abortion from pharmacies.

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This world-leading service led to significant reductions in abortion waiting times, gestational age and complication rates. Not only did this service obtain a 97 per cent client satisfaction rate, with 52,147 women using the service during its first year, it also set the standard of care for meeting women's needs in a time of crisis.

A cost-benefit analysis

A 2021 study estimates the change to telemedicine abortion will save the NHS over £3 million a year, through the reduced need for surgery beds, anaesthetics, and staff contact hours. Moreover, no clinic visits or ultrasound scans are required with this service. BPAS have also collaborated with other organisations to provide additional women's health information and support via the Pills by Post service. Examples of this include a partnership with CoppaFeel! to deliver breast-checking guides within the Pills by Post packages, and Covid-19 vaccine factsheets addressing the false fertility rumours. There are key benefits to delivering these messages directly into women's home at a time when they are thinking about their own health.

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Chapter Three
ASSISTED CONCEPTION

Introduction

The investigation and treatment of subfertility is often viewed as secondary to other reproductive health services. In 2020 the WHO stated that it “recognizes that the provision of high-quality services for family-planning, including fertility care, is one of the core elements of reproductive health.”

Worldwide, more than 48 million people are affected by infertility, defined by the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse.

Ultimately, an in-depth evaluation of the role of assisted conception as a medical issue in society is needed.

Some women are delaying childbearing until they have completed their education and established their career, a choice which was not an option for previous generations of women. The benefits to women to be financially secure and in stable relationship before they embark on motherhood must be weighed against the impact of age on reduction in fertility.

The consequences of infertility are significant and are recognised in levels of severity. They include fear, guilt and self-blame; marital stress, helplessness and depression, marital violence and social isolation, economic deprivation and loss of social status, violence induced suicide, starvation and disease. In some cultures, women are not accepted by society unless they have at least one living child.