Consultation Response Form

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1. About the National Secular Society

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

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

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

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

2. Comments on the consultation

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

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

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

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

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

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

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

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

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

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

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

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

Consultation questions

Q1.	**Do you consider that the temporary approval has had a positive impact on the provision of abortion services for women accessing these services with particular regard to safety, accessibility and convenience of services? Please provide your reasons.** Yes. The Royal College of Obstetricians and Gynaecologists and the Faculty of Sexual and Reproductive Healthcare have found that the risks of early medical abortions at homes compared to attending a hospital or approved setting are negligible. The risks are likely outweighed by the benefits of earlier, and therefore safer, abortions, in addition to more accessibility and patient choice as to the location of treatment. As Dr Edward Morris, President of the Royal College of Obstetricians and Gynaecologists, says: “The statistics…show that while many healthcare services have paused during the pandemic, access to abortion has been not only maintained but improved through the innovative use of telemedicine. This has reduced unnecessary visits to clinics and increased the safety of abortion care. It has also protected both women and their families, as well as healthcare professionals, from possible coronavirus infection and transmission. The data demonstrates why the temporary use of telemedicine for early medical abortion must be made permanent.” An additional benefit of remote access for all women seeking abortions is that it mitigates the risk of having to run the humiliating and daunting gauntlet of anti-choice protestors outside abortion facilities and helps to support confidentiality.

Q2.	**Do you consider that the temporary measure has had a positive impact on the provision of abortion services for those involved with service delivery? This might include greater workforce flexibility, efficiency of service delivery, value for money etc. Please provide your reasons.** Yes. The temporary measure has allowed healthcare staff to conduct timely, safe, remote consultations. This has mitigated the risk of Covid-19 transmission for both patients and healthcare professionals and has reduced unnecessary travel. The temporary measure has also facilitated

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

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

Q5.	**Outside of the Covid-19 pandemic, do you consider there are benefits in relation to safeguarding and women's safety in requiring them to make at least one visit to a service to be assessed by a clinician? Please outline those benefits.** No. For the reasons given above, for many women it is safer not to visit a service. It should therefore not be a requirement. In some cases, face to face consultations are a preferred choice for those seeking abortions, and so these should still be available for people who wish to attend in person or if the healthcare professional conducting the remote consultation feels that it would be safer to do so. We note that most objections to early medical abortions at home and remote consultations come from those who ideologically oppose abortion under all circumstances, and seek to make it harder for women to access abortion services. Many of these objections are rooted in religious teachings about sex. Religious ideology should not be permitted to determine healthcare policies, especially when accommodating religious beliefs will undermine the health, safety and well-being of patients of all religion and belief backgrounds.

Q6.	**To what extent do you consider making permanent home use of both pills could have a differential impact on groups of people or communities? For example, what is the impact on people with a disability or on people from different ethnic or religious backgrounds?** The risk of having to attend an approved setting for an abortion is especially high for women and girls from religious communities which are disapproving of abortion. Frequently, their doctor and their pharmacist may also be from the same community which presents a potential barrier to care because some women would be fearful of approaching such a healthcare professional for fear of breach of confidentiality. Younger women, girls and those without independent means may not have the resources or information to travel further afield to seek appropriate care. The main potential benefit of remote consultations to facilitate treatment for some vulnerable people is that they can consult from their own home without having to explain where they are going or having to consult a doctor or pharmacist from their local community.

Q7.	**To what extent do you consider that making permanent home use of both pills for EMA would increase or reduce the difference in access to abortion for people from more economically disadvantaged areas or between geographical areas with different levels of disadvantage?** We think it would reduce the difference in access to abortion from people

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

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

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