Abortion care

Consultation on draft guideline - Stakeholder comments table
12/04/19 to 31/05/19

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Alliance Pharmaceutical Ltd	Guideline	3	1 - 12	We agree that services should be more accessible to women who are considering a termination of pregnancy, however, there appears to be an omission of the guidance around assessment of women who may be presenting themselves for termination of pregnancy – if this is covered by another guideline, please would the author kindly reference this guideline into this section for the reader to follow up on and review? If there is no other guideline on this, please would the authors consider adding this in? Women present themselves for termination of pregnancy for a variety of reasons and some of these reasons could be reasonably addressed by the assessing clinician, **but only if identified;** this could lead to a woman to want to change her decision. An area that we are familiar with is nausea and vomiting of pregnancy (NVP) which commonly presents between week 4 and 7 of pregnancy and features in 80% of pregnancies (RCOG 2016); the average duration of symptoms is daily nausea/vomiting for 6 continuous weeks (Gadsby 1993). It is well documented that NVP symptoms, if left untreated, can lead to more women seeking a termination of pregnancy, as seen in 15% of NVP sufferers vs. <0.1% in the average pregnant woman (ONS 2016, Poursharif 2007) and where 18% of women with NVP report	Thank you for your comment. The committee agreed that it would be a matter for usual clinical practice to fully assess each patient. Recommendation 1.1.8 has, however been amended to say women should be provided with, or referred to support to make a decision if they request this.

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				seriously considering termination based on their symptoms alone (Mazzotta 2000). We would therefore request that the authors consider including a bullet point or section on the importance of assessing women who are considering a TOP secondary to a clinical cause which led to this decision, which could be managed/ reversed with treatment (be it psychological, social, conservative, pharmacological or otherwise) and the appropriateness of a referral; *prior* to undertaking the procedure. **REFS:** • Royal College of Obstetricians and Gynaecologists, The Management of Nausea and Vomiting of Pregnancy and Hyperemesis Gravidarum (Green-top Guideline No. 69). 22 June 2016. Royal College of Obstetricians and Gynaecologists: London. https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg69/. Accessed: July 2018. 2016 • Gadsby R et al. A prospective study of nausea and vomiting during pregnancy. Brit J Gen Pract. 1993:43:245–8 • Office for National Statistics. 2016. Statistical bulletin. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2016. + Scottish population	

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				data at http://www.isdscotland.org/Health-Topics/Maternity-and-Births/Publications/data-tables.asp. Accessed: March 2019 • Poursharif B, Korst LM, Macgibbon KW et al. Elective pregnancy termination in a large cohort of women with hyperemesis gravidarum. Contraception 2007; 76(6):451–5. Mazzotta, P., et al., Psychosocial morbidity among women with nausea and vomiting of pregnancy: prevalence and association with anti-emetic therapy. J Psychosom Obstet Gynaecol, 2000. 21(3): p. 129-36	
Anscombe Bioethics Centre	Guideline	General	General	We are concerned that the Guideline effectively presents abortion as an unequivocal good for women, and one moreover that seemingly has priority over other, more clearly medical requests. Unless the woman herself expresses a desire for delay, abortion must apparently be obtained at maximal speed and with minimal time for further reflection. However, many women are ambivalent about their abortions – see for example Törnbom M, Ingelhammar E, Lilja H, Svanberg B &Möller Decision-making about unwanted pregnancy. *Acta Obstetricia et GynecologicaScandinavica* 1999*;* 78: 636-641 – and/or experience them negatively, with some expressing deep unhappiness long after the abortion that they were not encouraged to think about the decision further. The alternative to abortion in the vast majority of cases is not some	Thank you for your comment. Improved access to abortion does not result in more abortions (Guttmacher institute) - but abortions that are performed at earlier gestations are safer and lead to less complications, which is the basis for improving access to them. There is also evidence (Cameron 2013) that most women (93%) are certain of their decision to not continue a pregnancy at the point at which they request an abortion. However, recommendation 1.1.8 has been amended to say women should be provided with, or referred to support to make a decision if they request this.

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				adverse medical event (pregnancy is not itself a disease), but the birth of a child who is normally accepted, raised and loved by the birth mother herself. Unless abortion is something we want to see more of, not less, why the need for so much haste?	
Anscombe Bioethics Centre	Guideline	4	9	We do not believe that women should be encouraged to self-refer, which will further lessen the opportunity for reflection and the chance of advice and information from health care professionals and others not financially or ideologically invested in abortion. It is also clear that the danger of coercion to abort is increased if the woman self-refers. The link between abortion and intimate partner violence is well-attested in the literature. Coercion to abort is an issue of which health professionals need to be aware, not least as there may be a need to liaise with social services and with those (including voluntary organisations) providing safe housing for pregnant women.	Thank you for your comment. The evidence identified in our review indicates that self-referral improves access & should result in abortions taking place at early gestations, and therefore with less complications. Our evidence review found that women want improved access and better information provision. Recommendation 1.1.8 has been amended to say women should be provided with, or referred to support to make a decision if they request this, in response to yours and others' comments. It is part of basic clinical care for healthcare professionals to ensure that women are not under physical or emotional duress and would form part of the assessment. The General Medical Council (https://www.gmc-uk.org/ethical-guidance/ethical-hub/adult-safeguarding) provides guidance about coercion and a reference to this has been added to the introductory text of the guideline.
Anscombe Bioethics Centre	Guideline	4	11	Some delay in obtaining abortions is simply unavoidable if conscientious objection is to be fully respected. There should be no attempt to put pressure on doctors to connect women with those who do or arrange abortions. After all, no such pressure is brought to bear with other interventions	Thank you for your comment. This recommendation is consistent with professional guidance (e.g., the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice) as healthcare professionals

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				(such as antibiotics for a virus) that a doctor believes are not in a patient's clinical interests but will/may do the patient/others harm. Doctors are not mere tools for satisfying social demands: it is in everyone's interests to have doctors of conscience who care about their patients' clinical interests, and the ethics of their profession more generally. More specifically, leaving space for conscientious objectors to operate is an important safety-net for women. We are aware of various anecdotal reports of women rethinking their decision to have an abortion after consulting with a GP with a conscientious objection, and also of women returning to a conscientious objector for advice when they experienced problems after an abortion. Conscientious doctors tend to win their patients' trust.	have a right to their personal beliefs and to opt out of performing a procedure, but cannot opt out of providing access. Additional information has been added to the rationale to clarify this. Recommendations 1.1.1 and 1.1.2 make it possible for a GP, should they have a conscientious objection, to give the patient information on how to self-refer and therefore not lead to a delay.
Anscombe Bioethics Centre	Guideline	4	13	It is anomalous that, while no funding is offered to access many other, more obviously medical procedures, such funding should be offered to access abortion in particular. Nor is there any offer to transport women, such as those at risk of intimate partner violence if they continue their pregnancies, to 'safe houses' or to pregnancy crisis centres that will support them emotionally and financially with pregnancy and motherhood. If women are not funded to access such positive, practical support, including from voluntary organisations, they should at very least be given information on this support. Women who change their minds last-minute about having abortions	Thank you for your comment. As this guideline covers abortion care, it is only within the scope of this guideline to make recommendations about funding for travel and accommodation for abortion care, not for other areas of healthcare. However, abortion is rather unique in terms of having a time limit during which the procedure can be performed and women often have to travel at very short notice compared with women having treatment for other conditions that may have several weeks' notice before an appointment. It was not within the scope of this guideline to make recommendations for women who decide to continue with pregnancy.

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				report not receiving such information from abortion providers.	
Anscombe Bioethics Centre	Guideline	5	4	We note a later reference (1.14.4) to advising women to seek emotional support if they need it after an abortion: such support may indeed be needed but comes a little late for those women who could and would have avoided the abortion altogether had they been encouraged to avail of counselling before the abortion or at least, given time and space to do so. We believe that, if counselling itself is not made compulsory, the offer of independent counselling at least should be mandatory as should a period for reflection. Ambivalence in women seeking abortions is not unusual (see reference in comment 1 above). The decision is simply too important to be rushed through, and the testimony of women who deeply regret their abortions should be heeded on this point.	Thank you for your comment. Recommendation 1.1.7 was included to ensure that women can wait longer to have an abortion if they would prefer this for whatever reason, including if she is still considering her options. Recommendation 1.1.8 has also been amended to say women should be provided with, or referred to support to make a decision if they request this. The rationale has been expanded to clarify this.
Anscombe Bioethics Centre	Guideline	7	3	We are concerned that there is no reference to the accepted medical fact that carrying a child to term protects against breast cancer, and that aborting the pregnancy will mean that this protective effect is lost. Health care professionals describing the impact of abortion on women's health need to ensure that this is known. Nor is it true that abortion carries no risk to fertility: the connection between abortion and PID, and PID and infertility (and ectopic pregnancy) is on the contrary recognised by the NHS.	Thank you for your comment. The American College of Obstetricians and Gynecologists concluded that the early studies on the relationship between induced abortion and breast cancer were flawed and that more rigorous, recent studies with prospective designs showed no causal relationship. Therefore, the committee agreed that there is no link between having an

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					abortion and increased risk of breast cancer and agreed women should be informed of this. The focus of this guideline is women having an abortion, not continuing pregnancy to term; therefore, benefits and risks associated with continuing a pregnancy was not considered as part of this guideline. However, there are risks associated with continuing a pregnancy to term and giving birth (e.g., urinary and bowel incontinence, prolapse) that may outweigh potential reductions in breast cancer risk. Whilst the NHS does recognise risk of PID, it also makes the statement that 'Having an abortion won't affect your chances of becoming pregnant and having normal pregnancies in the future' which is supported by recommendations from the RCOG that women can be reassured that there are no proven associations between abortion and infertility. It is the committees' experience that most women, if they know what to look for, will present with signs of infection and get treatment before PID develops and recommendations 1.2.9 and 1.14.3 cover giving women advice about potential complications.
Anscombe Bioethics Centre	Guideline	7	4	The confident assertion that abortion carries no mental health risks is unjustifed (see research by David Fergusson and others) especially in relation to abortion for foetal anomaly where the findings are especially marked (see e.g. Cope H, Garrett ME, Gregory S, *et al*. Pregnancy continuation and organizational religious activity following prenatal diagnosis of a lethal fetal defect are associated	Thank you for your comment. The committee were aware that the Academy of Medical Royal Colleges guidance showed that following an unwanted pregnancy, there was not an increased risk of having mental health problems in women who had an abortion compared with those who have birth. The Ferguson review cited did not control for pre-existing mental health problems,

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				with improved psychological outcome. *Prenat Diag* 2015; 35: 761–768). Women in certain groups particularly, such as those with pre-existing mental health problems, and those requesting an abortion for foetal anomaly, should be alerted to increased mental health risks by health professionals they consult.	which are more likely to occur again irrespective of whether a woman has an abortion. Further, the Ferguson review acknowledges that comparing women with an unwanted pregnancy that had an abortion with women with an unwanted pregnancy that decided to continue to term may not be the appropriate comparison. They said a more appropriate comparison may be to compare against women with an unwanted pregnancy who were refused an abortion. They were only aware of one study that did this (Gilchrist 1995), but this study showed a higher rate of psychotic illness in women refused an abortion. Therefore, the committee concluded that there was no robust evidence of a link between abortion and mental health problems.
Anscombe Bioethics Centre	Guideline	10		**Second left column** In view of the known risks of medical abortion, we would question the claim that less than 0.1% of women will have severe bleeding. Even up to 10 weeks, in one study, between 1.0% and 1.2% of women had 'excessive prolonged bleeding', and between 0.3% and 0.6% required a transfusion (Winikoff B *et al.* Extending Outpatient Medical Abortion Services Through 70 Days of Gestational Age. *ObstetGynecol* 2012; 120:1070–76).	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists. This guideline did not review the evidence comparing surgical and medical <13 weeks, and national statistics were used in lieu of an evidence review. Text has been added to the PDA to clarify where the data is taken from. The limitations of the national statistics were noted by the specialists, but it was agreed that it was not appropriate to report data from a single study when the evidence has not been reviewed.

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Anscombe Bioethics Centre	Guideline	23	15	Although there is already some research indicating a link between abortion and adverse mental health outcomes, we call for further research in this area, and in the area of the link between abortion and infertility caused by an infection. We would stress that such research should not be carried out exclusively by those who are linked to abortion providers or promoters (this is especially the case as abortion is almost always an elective procedure, heavily advertised by abortion providers). This is no more appropriate than having all research on the side-effects of smoking carried out by tobacco-industry funded researchers or indeed, tobacco industry personnel.	Thank you for your comments. NICE guidelines are only able to make research recommendations if an evidence review is conducted but limited or no evidence is identified by the searches. Therefore, it is not possible to make research recommendations in the areas you have suggested as the guideline did not include review questions in those areas.
Anscombe Bioethics Centre	Guideline	27	11	We reject as unsupported and indeed offensive any claim that improving abortion access will save money. This ignores the fact that many women will change their minds about abortion if given longer to think, and especially if offered support with their pregnancies - support which is currently available but which women are often not informed about even in the current system. Even leaving aside the health burden on women that abortion can create, and the financial impact of that burden, every society needs new members to function, nor should any new member be treated as simply a burden on society. For the NHS to end lives deliberately to avoid costs for the State that may (or may not) come with the life in question is of course no more appropriate in the prenatal stage than after birth. Why is NICE recommending that travel for the	Thank you for your comment. The guideline is for people who have requested an abortion and covers safe and effective abortion care. The alternative options to abortion, and care for women who choose to continue with pregnancy, are outside the scope of this guideline. Cost savings were based on economic modelling reported in evidence report A, appendix J. Assumptions made, included and excluded costs, perspective and weaknesses are discussed in detail there. The model had a tight perspective, not including productivity costs and making assumptions that improving access would not increase or decrease the number of terminations. The text in the main guideline has been edited to highlight that the cost savings only refer to procedure and adverse event costs. However,

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				purpose of abortion be funded for an expanded group of women, but not travel for the purpose of accessing pregnancy support and safe housing for women who would greatly prefer to have their babies and are considering abortion only with the utmost reluctance? In the case of a neonate with a life-threatening condition that could be treated effectively, or indeed in the case of maternal-fetal surgery, NICE would not simply ignore the likely benefit to the child. If cost-benefit analysis is used it must include the benefit to the child if it is born, just as with other perinatal interventions. Funding that helps avoid abortion is an inexpensive way greatly to extend the life of the child, on any econometric measure.	posited cost savings are a result of recommendations, not the reason for them.
Anscombe Bioethics Centre	Guidance	34	23	Although we do not wish to propose preparatory steps specifically directed at performing an abortion, we would at least resist any changes to preparatory steps that make the situation worse by withdrawing protection now available. That includes reducing the number of women having antibiotic prophylaxis for an abortion. PID, potentially causing infertility, is a very real risk, and if those affected, distressed by their inability to have a child naturally, seek IVF at a later stage, the financial costs will not be slight.	Thank you for your comment. The committee agreed based on their knowledge and comments from stakeholders, that the risk of antibiotic resistance and not being able to successfully treat infections in the future presents a greater risk than risk of PID following medical abortion as the risk of PID is greatest when instrumentation is introduced into the womb, which does not occur with medical abortion. Further, recommendations 1.2.9 and 1.14.3 cover giving women advice about potential complications and it is the committees experience' that most women, if they know what to look for, will present with signs of infection and get treatment before PID develops.
Betsi Cadwaladr University Health Board	Guideline	General	General	**General: recommendations 1.6.1, 1.9.1, 1.9.2 &1.12**	Thank you for your comment. This is another example of the need to develop closer links

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				Incomplete termination is considered in passing only. There is significant variation in the resources used to investigate, diagnose and manage women with women who present as an emergency to acute gynaecology NHS services. Independent abortion care providers have no way of recording the morbidity or costs of this activity. Data linkage is not set up to capture these women's pathways. The need for repeat evacuation is explicitly excluded as a complication in the statuary notification system. Further guidance or research to reduce variations in practice is lacking.	between the services that provide abortion. This guideline did not include a review question on management of incomplete abortion so the committee could not make recommendations in this area. This may be considered in a future update of this guideline.
Betsi Cadwaladr University Health Board	Guideline	General	General	**General recommendation 1.1.17 & 1.1.18** Consideration of the access of abortion services by vulnerable women is welcomed. More explicit address of the duty of care by an abortion care provider should be considered, especially in relation to human trafficking and domestic violence. Without explicit trained screening and signposting this abuse is hidden. Women and girls are then denied services that access safety and justice.	Thank you for your comment. The committee agreed that the recommendations on location of services should make it easier for vulnerable women to access termination of pregnancy services, particularly for women who may have difficulty getting out of the house or travelling. However, there is professional guidance about safeguarding and what to do if domestic abuse is suspected or disclosed by patient (e.g., the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-hub/adult-safeguarding) so the committee agreed it was not necessary to make recommendations in this area.
Betsi Cadwaladr University Health Board	Guideline	General	General	**Recommendation 1.6** Whilst the guideline refers to complex co-morbidities, birth by Caesarean section is common. A short birth interval is more likely to lead to abortion request, and presents a challenge for safe evacuation. We would welcome guidance	Thank you for your comment. No evidence was available for women who had a previous caesarean section in the evidence review on medical abortion between 10 and 24 weeks gestation and this was not included as a factor in the evidence review on medical abortion before 10

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				on medical <13+0 and surgical cervical priming regimens.	weeks. Therefore, the committee could not make specific recommendations about medical abortion regimens before 13 weeks in women who have had a caesarean. However, they agreed that the recommendations made in this guideline would also apply to this population. Similarly, whether or not a women had a previous caesarean was not included as a factor in the cervical priming evidence reviews as the committee agreed that this would not affect practice.
Betsi Cadwaladr University Health Board	Guideline	7	2 - 4	**Recommendation 1.2.1** We welcome the recommendation to dispel concerns about the long-term health risks posed by abortion care. However, obstetric concerns are not addressed. There remains medical concern about surgical evacuation and risks in future pregnancy: • late surgical procedures carry significant risk of cervical incompetence; future pregnancies with late miscarriage / extreme prematurity • repeated surgical evacuation carries a risk of placenta accreta spectrum; future deliveries would risk massive obstetric haemorrhage and hysterectomy. If there is evidence to refute these long-term health problems it would be useful to address them.	Thank you for your comment. The committee did not review the evidence for long term obstetric complications and were not aware of any guidance that covered this which could be referred to in the guideline. The committee acknowledge that there may be some evidence (although this was not reviewed as part of this guideline) of an association between abortion and risk of subsequent pre-term birth but agreed that the evidence for this is not definitive and so did not make recommendations. Therefore, recommendation 1.2.1 has been limited to risk of infertility, breast cancer and mental health problems. These specific complications were selected because they are covered in the RCOG guidelines, the committee agreed these are those that most commonly cause distress to women and for which the best available evidence shows that there is no increased risk (see evidence report B).
Betsi Cadwaladr University Health Board	Guideline	13	1 - 13	**Recommendation 1.3** Revision of advice to relax provision of anti-D is welcomed. Where rhesus status testing is	Thank you for your comment. It was not within the scope of this guideline to review methods for rhesus status testing.

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				indicated there is a wide variation in practice and costs. Clarification on whether the cheaper point of care testing is acceptable or not is welcomed.	
Betsi Cadwaladr University Health Board	Guideline	14	13	**Recommendation 1.4** Whether abortion care providers should adopt a policy of universal screen and selective prophylaxis, or one of selective antibiotic prophylaxis alone is not addressed by the guideline. This is pertinent as there is conflicting professional body guidance and significant variation in clinical practice. Untreated and / or undiagnosed STI in women and their sexual partners represents a significant health burden.	Thank you for your comment. There was no question about STI testing within the scope of this guideline so recommendations could not be made in this area. However, a cross-reference to NICE PH3 has now been included which covers guidance on interventions to prevent sexually transmitted infections. PH3 is currently being updated.
Betsi Cadwaladr University Health Board	Guideline	16 & 22	12 - 20 & 1 - 6	**Recommendations 1.9.2 & 1.15.5** We are concerned that the consequences of ongoing pregnancy following abortion care are not considered. Where less effective regimens are offered the risks posed both to women and their pregnancy must be fully and explicitly addressed. On diagnosing an ongoing pregnancy, women will either choose to access abortion care again, or continue with their pregnancy. When lost to follow-up, ongoing pregnancy might be diagnosed late in the second trimester.Vulnerable groups, particularly women with chaotic lifestyles are over-represented in abortion care services. Thus services are especially likely to lose women to follow-up. The	Thank you for your comment. Recommendation 1.9.2 explains the risks associated with taking mifepristone and misoprostol at the same time. This recommendation is only for women with gestations up to and including 9 weeks and covers the need to complete the recommended follow-up procedures (covered by recommendation 1.14.1 and 1.14.2) to confirm success of the abortion. Taken together, this should mean that if the abortion fails, the women will still be at a relatively early gestation and therefore at low risk for a repeat procedure. The introductory text has been amend to remind healthcare professionals to provide information and obtain informed consent in line with General Medical Council guidance (https://www.gmc-uk.org/ethical-guidance/ethical-

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				failure of periods to return is masked by contraception, especially LARC (Long Acting Reversible Contraceptives). A delayed repeat positive pregnancy test is misinterpreted as a new pregnancy compounding the delays in accessing care. Following failed abortion regimens, women who choose to continue abortion care face greater physical and psychological morbidity associated with advancing gestational age. Access to now more costly later regimens is problematic at later gestations. Women will also choose to continue with the ongoing pregnancy, whether or not a delayed diagnosis. The pregnancy is now considered high risk. An isolated significant bleed in early pregnancy, is associated with • Babies born with low birthweight Medical abortion drug regimens interrupt utero-placental function. Whether or not accompanied by bleeding, the link between poor obstetric outcomes and ongoing pregnancy is biologically likely. Confounding factors, lack of data linkage and poor maternal disclosure makes proven causation difficult. The anecdotal associations are: • Late miscarriage • Extreme prematurity It is dishonest not to consider these clinical risks in counselling women. It is an important area for research. We should not ignore these important factors in the risk-benefit analysis and the	guidance-for-doctors/consent) and the 2015 Montgomery ruling.

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				resource implications for the NHS. They must be discussed with the patients. The legalisation of home misoprostol allows access to the most effective medical regimens: women are able to increase the interval between the mifepristone and misoprostol administration without two clinic / hospital visits. We would encourage NICE to consider an analogous situation faced by the Human Fertilisation and Embryology Authority (HFEA). The motivation for the elective single embryo transfer (eSET) policy, which was introduced in 2009, dealt with the societal/ individual burden created by the high rate of multiple pregnancies, which carry significant risk. The decision-making about the number of embryos transferred moved away from simple models of informed user choice. Multiple embryo transfer was popular, since the pregnancy rates were higher and the idea of twins appealing to women. However multiple pregnancy carries a significant risk of prematurity. The cost of extreme prematurity to the individual, the family and society has driven the HFEA policy change. We hope NICE would provide the same quality of advice regarding the management of Early Medical Abortion (EMA). It is better to get the management right first time and prioritise quality over convenience.	

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British Association for Sexual Health and HIV - BASHH	Guideline	General	General	This consultation response has been submitted on behalf of the British Association for Sexual Health and HIV (BASHH) and has been informed by feedback from members of the BASHH Bacterial Special Interest Group. BASHH are broadly supportive of the proposed guidelines, although have identified a number of opportunities where we think the guidance can be strengthened. These comments are set out below.	Thank you for your comments.
British Association for Sexual Health and HIV - BASHH	Guideline	General	General	**Surgical termination** There is evidence that indicates that about 5% of women undergoing a surgical termination of pregnancy in which antibiotic prophylaxis is provided will develop upper genital tract infection. [1] This doubles to about 10% in women when antibiotic prophylaxis is not provided. It is unclear in the paper by Miller why 9% of women who received doxycycline alone, required additional antibiotics, this could reflect that 23% had a vaginal discharge, but 41% did complain of pain/malaise/unwell for > 7 days, suggesting that at least some of these women may have been treated for pelvic inflammatory disease (PID). The more recent studies by Crowley and Bjartling, would suggest lower estimates in untreated and treated women if adjusted for the selective use of antibiotic prophylaxis.[2, 3] Nevertheless, taken together they suggest that 2 to 5% of women given antibiotic prophylaxis may develop upper genital tract disease.	Thank you for your comment. There was no question about STI testing within the scope of this guideline so recommendations could not be made in this area. However, a cross-reference to NICE PH3 has now been included which covers guidance on interventions to prevent sexually transmitted infections. PH3 is currently being updated.

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				Doxycycline prophylaxis in surgical TOPs, as recommended in the guidelines, is effective in treating chlamydia but has limited efficacy against M. genitalium but may have some efficacy against some Bacterial vaginosis associated bacteria.[4, 5] Thus potential causes of upper genital tract disease following surgical TOP in women receiving doxycycline prophylaxis include bacterial vaginosis associated bacteria and Mycoplasma genitalium.[3, 5-7] Recent work by Price et quantified the risk of becoming infertile for an episode of inflammatory disease had about 3%.[8] Although this was estimate for Chlamydia it's not unreasonable to assume that this estimate can be applied to all causes of PID.[8] There is also good evidence that early treatment of PID reduces the risk of chronic sequelae such as infertility.[9] Thus a small but important proportion of women will still develop upper genital tract disease following surgical TOP even with doxycycline prophylaxis which could result in infertility (very small risk 0.5-.01%) which would be exacerbated by delay in seeking treatment. (Patients unaware of significance of symptoms) Administering prophylaxis without testing for chlamydia (or M genitalium) puts the person at risk of re-infection from an untreated partner (see below) and at increased risk of developing PID.[10]	

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				Given the imperative to reduce unnecessary antimicrobial therapy and the drive to use the correct antibiotic once the infection has been identified.[11] **We recommend testing all women for chlamydia, M genitalium and bacterial vaginosis if logistically possible and then administering the appropriate antibiotic prophylaxis providing the results are available before the TOP. New molecular tests for bacterial vaginosis are becoming commercially available which would make this technically possible.** [12, 13] **The guidance around surgical terminations is also unclear as to whether it recommends giving prophylaxis for STIs or post-op endometritis caused by vaginal flora. Although the guidance has picked the chlamydia regimen, it covers other bugs too, and should be given regardless of STI risk.** References 1. Low N, Mueller M, Van Vliet HA, Kapp N: **Perioperative antibiotics to prevent infection after first-trimester abortion**. *The Cochrane database of systematic reviews* 2012(3):Cd005217. 2. Crowley T, Low N, Turner A, Harvey I, Bidgood K, Horner P: **Antibiotic prophylaxis to prevent post-abortal upper genital tract infection in women with bacterial vaginosis: randomised**	

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				controlled trial. *BJOG: an International Journal of Obstetrics & Gynaecology* 2001, **108**(4):396-402. 3. Bjartling C, Osser S, Persson K: **The association between Mycoplasma genitalium and pelvic inflammatory disease after termination of pregnancy**. *BJOG: An International Journal of Obstetrics & Gynaecology* 2010, **117**(3):361-364. 4. Petrina MAB, Cosentino LA, Wiesenfeld HC, Darville T, Hillier SL: **Susceptibility of Endometrial Isolates Recovered from Women with Clinical Pelvic Inflammatory Disease or Histological Endometritis to Antimicrobial Agents**. *Anaerobe* 2019, **56**:61-65. 5. Soni S, Horner P, Rayment M, Pinto-Sander N, Naous N, Parkhouse A, Bancroft D, Patterson C, Fifer H: **British Association for Sexual Health and HIV national guideline for the management of infection with Mycoplasma genitalium (2018)** In.: BASHH; 2018. 6. Brunham RC, Gottlieb SL, Paavonen J: **Pelvic Inflammatory Disease**. *New England Journal of Medicine* 2015, **372**(21):2039-2048. 7. Miller L, Thomas K, Hughes JP, Holmes KK, Stout S, Eschenbach DA: **Randomised treatment trial of bacterial vaginosis to prevent post-abortion**	

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				13. Van Der Pol B, Daniel G, Kodsi S, Paradis S, Cooper CK: **Molecular-based Testing for Sexually Transmitted Infections Using Samples Previously Collected for Vaginitis Diagnosis**. *Clin Infect Dis* 2019, **68**(3):375-381.	
British Association for Sexual Health and HIV - BASHH	Guideline	General	General	**Medical termination** The evidence indicates that the risk of developing upper genital tract disease is lower <1% in patients who receive medical terminations compared to surgical termination even with antibiotic prophylaxis.[1, 2, 3, 4] Nevertheless there remains a risk which is likely to be higher in women with chlamydia and M genitalium infection and possibly a risk with bacterial vaginosis (there is no data on this).[2] In the study by Bjartling 9% of women with M genitalium undergoing medical TOP developed PID compared to 19% undergoing surgical PID with prospective cohort studies indicating low risk of women with M genitalium developing PID.[2, 5, 6] The proposal for selective use of antibiotics based on testing for chlamydia seems reasonable, providing the result is available before the procedure. Testing is not currently widely available for M. genitalium but such testing should be considered. However the selective criteria for testing are not defined, apart from the 2012 BASHH guidelines on safer sex advice which observed that "No systematic reviews, meta-analyses, or original	Thank you for your comment. In response to stakeholder comments, the recommendations for antibiotic prophylaxis for medical abortion have been amended to say they should not be routinely given rather than given to those at risk of STIs as evidence on STI risk was not reviewed as part of this guideline so this population could not be defined. However, the committee agreed that prophylaxis may be appropriate for high risk women or those who would find it difficult to access treatment at a later date in response to a positive screen for sexually transmitted infections. The committee discussion in evidence report D and the rationale and impact has been updated to reflect these changes.

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				studies describing methods to systematically target potential candidates for interventions were found." The guideline includes as those at risk directly relevant to women requesting a TOPs "adolescents", "people from, or who have visited countries with high rates of HIV and/or other STIs" and "individuals with frequent partner change or sex with multiple concurrent partners, early onset sexual activity, previous bacterial STI, attendance as a contact of STI". Review of NATSAL, ClaSS and the recent multiple parameter evidence synthesis of the natural history of chlamydia infection would suggest persons with the following characteristics would be considered at risk of chlamydia. [7-9] 1) Women under 24 yrs particularly under 20 yrs 2) Women with new partner and/or two or more partners in the previous year 3) With women at greater risk a. Practising unprotected sexual intercourse b. from more deprived areas being • These criteria would also apply to M genitalium[10] **Treating infected individuals without treating their partner puts them at risk of re-infection.[5, 11] There is evidence that the risk of PID developing in women infected with**	

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				chlamydia increases on re-infection.[12] Thus if selective testing for chlamydia and M genitalium is to be introduced this should also happen in women undergoing surgical TOPs. References 1. Low N, Mueller M, Van Vliet HA, Kapp N: **Perioperative antibiotics to prevent infection after first-trimester abortion**. *The Cochrane database of systematic reviews* 2012(3):Cd005217. 2. Bjartling C, Osser S, Persson K: **The association between Mycoplasma genitalium and pelvic inflammatory disease after termination of pregnancy**. *BJOG: An International Journal of Obstetrics & Gynaecology* 2010, **117**(3):361-364. 3. Shannon C, Brothers LP, Philip NM, Winikoff B: **Infection after medical abortion: a review of the literature**. *Contraception* 2004, **70**(3):183-190. 4. Fjerstad M, Trussell J, Sivin I, Lichtenberg ES, Cullins V: **Rates of serious infection after changes in regimens for medical abortion**. *The New England journal of medicine* 2009, **361**(2):145-151. 5 Soni S, Horner P, Rayment M, Pinto-Sander N, Naous N, Parkhouse A, Bancroft D, Patterson C, Fifer H: **British Association for Sexual Health and HIV**	

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				national guideline for the management of infection with Mycoplasma genitalium (2018) In.: BASHH; 2018 6. Tosh AK, Van Der Pol B, Fortenberry JD, Williams JA, Katz BP, Batteiger BE, Orr DP: **Mycoplasma genitalium among adolescent women and their partners**. *Journal of Adolescent Health* 2007, **40**(5):412-417. 7. Sonnenberg P, Clifton S, Beddows S, Field N, Soldan K, Tanton C, Mercer CH, da Silva FC, Alexander S, Copas AJ *et al*: **Prevalence, risk factors, and uptake of interventions for sexually transmitted infections in Britain: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal)**. *The Lancet* 2013, **382**(9907):1795-1806. 8. Price MJ, Ades AE, Angelis DD, Welton NJ, MacLeod J, Soldan K, Turner K, Horner PJ: **Incidence of *Chlamydia trachomatis* infection in women in England: two methods of estimation**. *Epidemiology & Infection* 2014, **142**(3):15. 9. MacLeod J, Salisbury C, Low N, McCarthy A, Sterne JAC, Holloway A, Patel R, Sanford E, Morcom A, Horner P *et al*: **Coverage and uptake of systematic postal screening for genital *Chlamydia trachomatis* and prevalence of infection in the United Kingdom**	

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				general population: cross sectional study. *BMJ* 2005, **330**(7497):940. 10. Sonnenberg P, Ison CA, Clifton S, Field N, Tanton C, Soldan K, Beddows S, Alexander S, Khanom R, Saunders P *et al*: **Epidemiology of Mycoplasma genitalium in British men and women aged 16-44 years: evidence from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)**. *International journal of epidemiology* 2015, **44**:1982-1994. 11. Nwokolo NC, Dragovic B, Patel S, Tong CY, Barker G, Radcliffe K: **2015 UK national guideline for the management of infection with Chlamydia trachomatis**. *Int J STD AIDS* 2016, **27**(4):251-267. 12. Hillis SD, Owens LM, Marchbanks PA, Amsterdam LE, Mac Kenzie WR: **Recurrent chlamydial infections increase the risks of hospitalization for ectopic pregnancy and pelvic inflammatory disease**. *American Journal of Obstetrics and Gynecology* 1997, **176**(1, Part 1):103-107.	
British Association for Sexual Health and HIV - BASHH	Guideline	13		**1.4.1** Whilst we think the recommendations and evidence summery regarding antibiotic prophylaxis (section 1.4 and Evidence review D) look reasonable, we are concerned that for	Thank you for your comment. In response to stakeholder comments, the recommendations for antibiotic prophylaxis for medical abortion have been amended to say they should not be routinely given rather than given to those at risk of STIs as

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				medical terminations, antibiotics are only recommended if the woman is at higher risk of sexually transmitted infections (STIs), but there is no information about who these women may be. Whilst this is partially addressed in the evidence review, which states that BASHH guidance exists (Safer sex guideline 2012) and that making recommendations is outside the scope of the review conducted, as the aim of this recommendation is to reduce unnecessary use of antibiotics we are concerned that there may be an unmet need if users of the guidelines are not confident in making the assessment. We are also concerned that there is a lack of a recommendation of any testing for STIs. The rationale states that chlamydia treatment should be given as it is the most common STI, however there is no clear indication on who should receive treatment. We suggest that good practice would encourage the offering of a test so that if complications occur after the procedure, this information can guide prudent antibiotic usage.	evidence on STI risk was not reviewed as part of this guideline so this population could not be defined. However, the committee agreed that prophylaxis may be appropriate for high risk women or those who would find it difficult to access treatment at a later date in response to a positive screen for sexually transmitted infections. The committee discussion in evidence report D and the rationale and impact has been updated to reflect these changes. There was no question about STI testing within the scope of this guideline so recommendations could not be made in this area. However, a cross-reference to NICE PH3 has now been included which covers guidance on interventions to prevent sexually transmitted infections. PH3 is currently being updated.
British Association for Sexual Health and HIV - BASHH	Evidence Review B	General	General	**Information needs of women undergoing a termination of pregnancy** Given that advice on potential complications should be provided to patients and what to do if these should occur and how to minimise risk of long-term complications, it is unclear why this issue is not explicitly addressed in *"Information*	Thank you for your comment. Giving women advice about potential complications is covered by recommendations 1.2.9 and 1.14.3. There was no question about STI testing within the scope of this guideline so recommendations could not be made in this area. However, a cross-reference to NICE PH3 has now been included which covers guidance on interventions to prevent sexually

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				needs of women undergoing a termination of pregnancy". The benefits and harm section states *"Women also wanted information about what to expect from the procedure, including associated pain and bleeding, in a range of formats, using simple language, and valued the opportunity to ask questions*." But in the previous paragraph states *"Therefore, the committee agreed that women should be reassured that they are not at any higher risk of any significant long-term health problem, including infertility, as a result of having a termination."* Based on the information provided above this is not strictly true as the low risk of infertility can be reduced further by 1) completing doxycycline prophylaxis when having a surgical TOP 2) Getting tested for chlamydia/M genitalium if at risk, taking the medication and ensuring their partner is treated 3) seeking care early if pain develops and persists. The POPI study indicates that if suitably informed women with symptoms of PID will seek care.[1, 2] Finally given that information provided to patients should also give information on risk, it would seem appropriate to detail in the leaflet risk factors for chlamydia and M genitalium including re-infection and why these are being tested for selectively in	transmitted infections. PH3 is currently being updated.

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				some individuals and how they can prevent infection in the future. References 1. Price MJ, Ades AE, Soldan K, Welton NJ, Macleod J, Simms I, DeAngelis D, Turner KM, Horner PJ: **The natural history of Chlamydia trachomatis infection in women: a multi-parameter evidence synthesis**. *Health Technol Assess* 2016, **20**(22):1-250. 2. Oakeshott P, Kerry S, Aghaizu A, Atherton H, Hay S, Taylor-Robinson D, Simms I, Hay P: **Randomised controlled trial of screening for Chlamydia trachomatis to prevent pelvic inflammatory disease: the POPI (prevention of pelvic infection) trial**. *BMJ* 2010, **340**:1642.	
British Association of Abortion Care Providers (BSACP)	Guideline	General	General	**language** Language/terminology 1) 'Termination of Pregnancy' (TOP) seems outdated. We are concerned the use of TOP instead of 'abortion' appears inaccurate and potentially stigmatising. One Service analysed their website traffic and found that the word 'abortion' was typed into searches to access information. A more gender-inclusive use of language should be considered to include all those for whom the	Thank you for your comments. In response to yours and others' comments the title of the guideline has been amended to 'Abortion Care', and the term 'abortion' has replaced 'termination of pregnancy' in the recommendations. The introductory text to the guideline has been amended to clarify that this guidance is relevant for women and people who are pregnant but do not identify as women. However, for simplicity of language, the term women is still used throughout the guideline.

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				guideline is intended: women and non-binary/transgender people.	
British Association of Abortion Care Providers (BSACP)	Guideline	4	23	The proposal that waiting time between assessment and treatment should ideally not exceed 1 week appears unreasonably long, especially considering the goal of decreasing waiting times.	Thank you for your comment. The committee agreed that 1 week was a reasonable timeframe when considering different types of procedures, possible need for referrals and need to determine medical eligibility. However, the rationale has been amended to make it clear that same day services can be provided where possible.
British Association of Abortion Care Providers (BSACP)	Guideline	5	4	We are pleased at the recommendation regarding compulsory counselling and the supporting evidence and agree with this practice.	Thank you for your comments.
British Association of Abortion Care Providers (BSACP)	Guideline	5	7	We support the important recommendation on phone consultation. It could be phrased using stronger language (e.g. "provide termination of pregnancy consultations by phone or video call where possible and where the patient prefers this").	Thank you for your comment. There was evidence from the qualitative review that remote consultations may improve access to termination of pregnancy services but no evidence was found for this outcome in the quantitative review. Therefore, in the absence of differences on any of the other outcomes, there was not sufficient evidence to support a strong recommendation.
British Association of Abortion Care Providers (BSACP)	Guideline	5	13	We support NICE's recommendation to maximise the role of nurses and midwives in providing abortion care. BSACP emphasises that training this workforce needs to be properly commissioned. We support both the NHS and independent providers in playing a role with training.	Thank you for your comment, the recommendations about the workforce in this guideline should support the commissioning of training that will support services to deliver these recommendations.
British Association of Abortion Care Providers (BSACP)	Guideline	7 - 10		**Table** The term 'operation' used to describe surgical treatment appears unhelpful. This may enforce current misunderstandings about the type of	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline, which is intended to be used by patients. The PDA has been developed in collaboration with patient

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				treatment. 'Surgical procedure' is a more accurate description of this treatment.	representatives and specialists who agreed the term 'operation' was clearer to patients.
British Association of Abortion Care Providers (BSACP)	Guideline	7 - 10		**Table** Similar language point as above: Medical 'procedure' generates misunderstandings. Instead, consider rephrasing as "the medications/tablets may be taken at home or in a clinic or hospital...".	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA does not include the wording you refer to.
British Association of Abortion Care Providers (BSACP)	Guideline	8		**Table** The difference in the time in the column on Medical treatment (sub-header before 10+1) and just below when describing women being able to take misoprostol at home (before 10+0) is probably due to the current interpretation of the UK law. It would be helpful to explain this discrepancy is due to current legal requirements, rather than a restriction that is evidence-based or clinically necessary evidence. The current different gestational ages appear rather random.	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The language and formatting of the decision aid has been amended and does not include this discrepancy between 10+0 and 10+1. It is clear in the decision aid that whether or not you can take the medicine at home is dependent on gestational age and legal restrictions.
British Association of Abortion Care Providers (BSACP)	Guideline	8 - 10, 13		We noted the lack of consistent gestation limits on different pages of the guidance: 1) in the table comparing medical and surgical treatments - (for medicine) 'before 10+1' and 'after 10+0' - (for surgery) 'before 14+0' and 'after 14+0' 2) on p.13 lines 3 and 5 - For Anti-D - offer Anti-D after 9+6…do not offer prophylaxis before 10+0 Would it be possible to simplify gestational age and avoid confusion - for instance in the table 'up to and including 9+6/10+0 and above' for medical	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists. The gestational age limits included in the table corresponded to gestational limits in the evidence reviews. However, these are being reviewed in the PDA to make the resource easier to use in practice. The gestational limits used in the recommendations on anti-D prophylaxis have been amended to align with recommendations on expulsion at home for early medical abortion.

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				and 'up to and including 13+6/after 14+0 for surgical?	
British Association of Abortion Care Providers (BSACP)	Guideline	10		**Table** The gestational age bandings are very different for explaining complication rates. Would it be possible to make the table more user-friendly? For example, patients having medical treatment complication rates: - up to and including 9+6 – to fit for women having home treatment/inpatient treatment for medical reasons - 10 weeks and over for inpatient medical treatment. The available evidence may not fit those gestation dates, but from an individual's perspective, are the risks really the same for home medical treatment at 7 weeks, as for inpatient treatment at 12+6 weeks? If not, it is a shame the complication rates are intermixed.	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists. The gestational age limits included in the table corresponded to gestational limits in the evidence reviews. However, these are being reviewed in the PDA to make the resource easier to use in practice. Two separate PDAs are being created, covering <14 weeks and 14 to <24 weeks. Complication rates before 14 weeks are taken from national statistics (footnoted in the table), weighted by the proportion of abortions carried out at each time point.
British Association of Abortion Care Providers (BSACP)	Guideline	13	7	The Instructions for Anti-D after surgical treatment are not clear. 'Consider giving Anti-D … before 10 weeks' – does that mean to give it or not to?	Thank you for your comment. The absence of evidence for this review question meant that the committee could not make a strong recommendation regarding the use of anti-D prophylaxis after surgical abortion before 10 weeks. Instead they made a recommendation to consider its use, and a research recommendation for this area.
British Association of Abortion Care Providers (BSACP)	Guideline	14	18	The link for guidance on VTE prophylaxis concerns inpatients and thus is not useful for most of abortion care. The RCOG guidance recommends prophylaxis with four risk factors,	Thank you for your comment. The NICE guideline referred to covers hospital acquired VTE. However, the risk assessment is concerning all pregnant women, not just those who are

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				thus including age >35 years, BMI >30 kg/m^2, smoker and para 3. This will be difficult to implement and further research and guidance on clinical realities is needed.	inpatients. However, as explained in the committee discussion in evidence report E, this risk assessment may overestimate risk as it is a risk assessment for term pregnancies, or for women continuing pregnancies to term, where coagulation factors will be higher than for women having an abortion at earlier gestations. On reflection, and in response to comments from stakeholders, the committee have removed the recommendation which cross-referred to this risk assessment. The committee discussion in evidence report E has been updated to reflect this change. However, as this question was concerned with thromboprophylaxis for women who have been identified as requiring it, and not risk assessment for VTE, the committee were not able to make recommendations about who may need thromboprophylaxis.
British Association of Abortion Care Providers (BSACP)	Guideline	15	10	Excellent guidance on early TOP prior to explicit ultrasound evidence of an intrauterine pregnancy. However, we are missing further evidence on the role of routine ultrasound assessment in abortion care. See the 2019 guidance on abortion care by the Institute of Obstetricians & Gynaecologists/Royal College of Physicians of Ireland: https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2018/12/FINAL-INTERIM-CLINICAL-GUIDANCE-TOP-12WEEKS.pdf	Thank you for your comment. The evidence on the role of routine ultrasound assessment in abortion care was not reviewed as part of this guideline. Therefore, the committee could not make recommendations in this area. However, a future update of the guideline may consider that question.
British Association of Abortion Care Providers (BSACP)	Guideline	15	19	This recommendation will be challenging for some services without 24-hour phone access	Thank you for your comment. The recommendation does not specify that this phone

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					service needs to be provided by the abortion service.
British Association of Abortion Care Providers (BSACP)	Guideline	16	12 - 20	There is evidence that the risk of ongoing pregnancy with simultaneous medication is only very slightly higher (overall: 95% success with the SIM regimen vs 97% with the interval regimen), which does not seem to translate into a large difference clinically. [Lohr PA, Starling JE, Scott JG, Aiken ARA. Simultaneous compared with interval medical abortion regimens where home use is restricted. *Obstet Gynecol* 2018;131:635–641]. It is really important to illustrate the small difference in risk in more detail. "Higher" by itself is not very helpful to decision-making.	Thank you for your comment. This information has now been added to Evidence report H and the Rationale and Impact section in the guideline.
British Association of Abortion Care Providers (BSACP)	Guideline	30	8	We are aware of other recent evidence about the minimal risk of sensitising Rh-negative patients having abortions at less than 14 weeks to further support the Committee's recommendation on limited use of Anti-D: • Wiebe ER, Campbell M, Aiken ARA, Albert A. Can we safely stop testing for Rh status and immunizing Rh-negative women having early abortions? A comparison of Rh alloimmunization in Canada and the Netherlands. *Contraception X* 2019;1:100001. • Horvath S, Luning Prak E, Shreiber C. A highly sensitive flow cytometry protocol shows fetal red blood cell counts in the first-trimester maternal circulation well below the threshold for Rh sensitization. *Contraception* 2018;98:332.	Thank you for your comment. The results of the studies listed are reassuring and in line with the recommendations made by the Committee. These studies do not meet the inclusion criteria for the anti-D systematic review (either because they are indirect evidence from women who are not having an induced abortion [de Haas], mixed population with no subgroup results presented for women having induced abortions [Wiebe] or because no anti-D was given [Horvath]).

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				de Haas M, Thurik FF, van der Ploeg CBP, Veldhuisen B, Hirschberg H, Soussan AA, et al. Sensitivity of fetal *RHD* screening for safe guidance of targeted anti-D immunoglobulin prophylaxis: prospective cohort study of a nationwide programme in the Netherlands. *BMJ* 2016;355:i5789.	
British Association of Abortion Care Providers (BSACP)	Guideline	32	17 - 19	The advice on less use of prophylactic antibiotics is very welcome. However, the Committee did not include advice on offering screening for sexually transmitted infections (STIs). We are surprised by the inaccurate term "those at the highest risk for STIs" to be used as marker for prophylactic antibiotics. This warrants further explanation and evidence as to how to ensure what constitutes a 'highest risk' in a population with unwanted pregnancies.	Thank you for your comment. In response to stakeholder comments, the recommendations for antibiotic prophylaxis for medical abortion have been amended to say they should not be routinely given rather than given to those at risk of STIs as evidence on STI risk was not reviewed as part of this guideline so this population could not be defined. However, the committee agreed that prophylaxis may be appropriate for high risk women or those who would find it difficult to access treatment at a later date in response to a positive screen for sexually transmitted infections. The committee discussion in evidence report D and the rationale and impact has been updated to reflect these changes. There was no question about STI testing within the scope of this guideline so recommendations could not be made in this area. However, a cross-reference to NICE PH3 has now been included which covers guidance on interventions to prevent sexually transmitted infections. PH3 is currently being updated.
British Islamic Medical Association	Guideline	General	General	**An overview of Islamic legal and bioethical considerations regarding termination of pregnancy**	Thank you for your comments. The Equalities Impact Assessment form published alongside this guideline details how equality issues were considered. As with all NICE guidance, this

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				The UK is currently home to at least 3.4 million Muslims [1] who, to varying degrees, will refer to Islamic jurisprudential and ethical teachings to inform/guide their healthcare decisions, including that of termination of pregnancy (TOP). It is therefore pertinent for TOP providers to be aware of this system of ethics used by some of their patients, in order to effectively engage in patient-centred shared decision making with them. TOP is not permitted in Islamic law, except under legal exception [2-5]. The applicability of such exceptions depends on the gestational age of the foetus, as the gestational age at which ensoulment is believed to occur dictates the foetus' subsequent full legal status. There is a difference of opinion among contemporary Muslims jurists, of differing legal schools of thought, about when ensoulment occurs with two major opinions being at **120 days**[1] **gestation (or 19 weeks post-LMP** [6]) and **40 days**[2] **gestation (or ~8 weeks post-LMP**)[3]. *Before ensoulment*, TOP is permitted to avoid *intolerable* difficulty or *severe* loss/hardship associated with the pregnancy or rearing the child thereafter. Common examples would include TOP to prevent threat to the life of the mother, severe	guideline should be read in conjunction with the NICE guideline on Patient Experience in Adult NHS Services which makes recommendations on knowing the patient as an individual and tailoring healthcare for each patient, and which is cross referenced in recommendation 1.2.5 of this guideline. The committee could not make specific recommendations about providing training for healthcare professionals on the issues you highlight as there are many groups of women that may have differing needs, and it is not possible to make exhaustive reference to all circumstances.

[1] Hanafi, Shafi'I and Ja'fari schools.
[2] Maliki and Hanbali schools
[3] Although some other jurists have also argued 80 days or 5 months.

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				injury (or substantial risk thereof) to the physical/mental health of the mother, severe hardship associated with rearing a child with a congenital abnormality (judged on a case-by-case basis) and severe hardship associated with the social circumstances of the woman's pregnancy (although financial difficulties are generally not acceptable in isolation). *After ensoulment*, some Islamic jurists may permit TOP under certain situations where the mother's life is at risk. In any case, where a patient indicates Islamic law to be influential to their decision on TOP, consultation of that patient with a qualified and experienced Islamic scholar for the purposes of providing individualised, case-by-case guidance may be appropriate and helpful. Furthemore, Islamic law does not permit Muslim healthcare professionals, even whilst living and working in the UK, to approve or conduct TOP procedures in patients (Muslim or otherwise) requesting TOP not fulfilling Islamic legal criteria. Apart from Islamic jurisprudential teachings, Muslim patients' TOP decision may also be influenced by ethical/theological beliefs [7, 8], including about the wrongness of abortion from day one, fate and acceptance of God's will, how it is not their decision to interfere in God's creation, the blessings of caring for a handicapped child, the reward associated with undergoing hardship in pregnancy and thereafter, the belief in hardship	

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				being a test from God, fear of God's punishment for terminating a pregnancy due to putting one's own interests before that of an unborn child, and, the importance of self-sacrifice to bring a child, albeit through difficulty or illness, into the world . These considerations may be influential for a Muslim patient in deciding to continue her pregnancy, despite Islamic jurisprudential edicts permitting TOP in her case. Furthermore, cultural (non-religious) factors may also affect Muslim patients' decisions for TOP. This may include a perceived stigma from their local community or pressure from their partner, spouse or family members (both in favour of or against TOP). It may also include secular beliefs about the immorality of bringing children into the world with severe foetal anomaly and subjecting them to suffering. Apart from the above, Muslim patients' decision to terminate a pregnancy will also, naturally, be influenced by factors that patients of other (or no) faith are also influenced by, including ease of access to TOP services, information about the procedure, concerns regarding safety, confidentiality and the care they will receive, their emotional/psychological health after the procedure, and the subsequent support available to guide their reproductive decision making, including the use of contraception.	

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				Importantly, just because a patient appears Muslim, or admits to belonging to the Islamic faith, should not prompt healthcare professional to assume that such patients will follow the letter of their faith. It is therefore paramount that healthcare professionals are sufficiently trained to sensitively gauge and appreciate the variety and interplay of factors that a Muslim patient will consider, including (but not limited to) the teachings of their faith, in order to discuss the various options available to them (including continuation of pregnancy). In the context of these various factors that influence Muslim patients (and Muslim doctors') decisions to participate in TOP, the British Islamic Medical Association offers the following responses to the recent draft NICE guideline on Termination of Pregnancy, published 12 April 2019. References 1. Ons.gov.uk. (2019). Muslim population in the UK 2018 - Office for National Statistics. [online] Available at: https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/muslimpopulationintheuk/ [Accessed 21st May 2019]. 2. Sekaleshfar F. Abortion Perspectives of Shiah Islam. *Studies in Ethics, Law, and Technology*. 2008. 2(3): Article 4. 3. Ekmekci P. Abortion in Islamic Ethics, and How it is Perceived in Turkey: A Secular,	

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				Muslim Country. *J Relig Health*. 2017. 56(3): 884–895. 4. Al-Matary A. et al Controversies and considerations regarding the termination of pregnancy for Foetal Anomalies in Islam. *BMC Med Ethics*. 2014. 15:10. 5. Asmen O. Abortion in Islamic Countries – Legal and Religious Aspects. *Medicine and Law*. 2004. 23:73-89 6. Lmo.ir (2016). Mu'āyināt Siqt-i-Darmāni. Available at: http://lmo.ir/web_directory/54768-مشاهده-یک-خدمت.html?id=54&cnt_id=54&sisOp=view [Accessed 21st May 2019] 7. Ahmed S. et al. Attitudes towards prenatal diagnosis and termination of pregnancy for thalassaemia in pregnant Pakistani women in the North of England. *Prenatal Diagnosis*. 2006. 26 (3): 248-257 Ahmed S. et al. The influence of faith and religion and the role of religious and community leaders in prenatal decisions for sickle cell disorders and thalassaemia major. *Prenatal Diagnosis*. 2006. 26 (9): 801-809	
British Islamic Medical Association	Guideline	4	4	Information should be tailored specifically to account for the beliefs, values and concerns of Muslim patients, in a sensitive manner, to aid them (and those whom the patient freely chooses to accompany them, including their spouse/family members) to engage in a process of informed decision making, including the option of continuing pregnancy and its implications	Thank you for your comments. As with all NICE guidance, this guideline should be read in conjunction with the NICE guideline on Patient Experience in Adult NHS Services which makes recommendations on knowing the patient as an individual and tailoring healthcare for each patient, and which is cross referenced in recommendation 1.2.5 of this guideline.

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British Islamic Medical Association	Guideline	4	6	In cases where a Muslim woman does choose TOP, prompt referral is essential due to the time limit of ensoulment under which the Islamic legal exception for TOP is likely to apply, should the patient see this as influential to her decision.	Thank you for your comment, the recommendations made by this guideline on self-referral (1.1.2) and reduction of waiting times (1.1.5, 1.1.6) will improve swift access to care.
British Islamic Medical Association	Guideline	4	11	Muslim doctors and trainees (and other healthcare professionals, including students, nurses and midwives) may conscientiously object to refer, approve or participate in TOP procedures/services for both Muslim and non-Muslim patients, regardless of circumstances, gestational age or the fulfilment of Islamic legal criteria. Services should therefore be designed in a way which do not pressurise Muslim healthcare professionals against their right to conscientiously object, but also do not delay TOP service provision to women who will nonetheless seek an appointment/referral through another healthcare professional or, self-refer. Muslim clinicians should however provide care for women suffering from complications due to TOP, whatever the reason or grounds for that TOP.	Thank you for your comment. The management of conscientious objection is the right of all healthcare professionals and is covered by legislation and relevant guidance (e.g. the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice).Therefore, it is not necessary to make additional recommendations relating to it in this guideline.
British Islamic Medical Association	Guideline	4	18	Minimal delay in the provision of TOP for Muslim patients is essential, due to the legal time limit of ensoulment. Healthcare professionals should therefore enquire about whether a Muslim patient has any specific time limits in mind which would affect her TOP decision and ensure swift access to TOP services accordingly, including prioritisation.	Thank you for your comment, the recommendations made by this guideline on self-referral (1.1.2) and reduction of waiting times (1.1.5, 1.1.6) will improve swift access to care. It would not however be possible to prioritise one group of women over all other groups.
British Islamic Medical Association	Guideline	5	21	It is a reality that the majority of TOPs in the England are carried out under the Royal College	Thank you for your comment. Conscientious objections is covered by legislation and

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				of Obstetricians and Gynaecologists (RCOG) Ground C during the first trimester, due to unwanted pregnancy, though not necessarily any real or foreseeable risk to the mental health of the pregnant woman [9]. Furthermore, the British Medical Association (BMA) also issued that "Given the risks associated with pregnancy and childbirth, and the risks of a woman having to continue a pregnancy against her wishes (compared with the minor risks associated with early medical abortion), there will always be medical grounds to justify termination in the first trimester". On this, Islamic law requires the presence of intolerable difficult or severe hardship/loss regarding the mental/physical health of the pregnant woman to justify a TOP. Therefore, the technique of utilising relative risk does not hold legal weight in Islamic abortion law. For this reason, it is not unlikely that a proportion of Muslim clinicians would conscientiously object to partaking in TOP procedures in (the majority of) women requesting TOP on the grounds of unwanted pregnancy, even if it be integral to their speciality training curriculum. In this regard, NHS Trusts, higher educational institutions, Royal Colleges, and postgraduate deaneries involved in speciality training should provide clear information and guidance on the process of conscientious objection. Furthermore, an environment of tolerance for objecting trainees should prevail and under no circumstances should trainees perceive disadvantage in obtaining speciality training posts	professional guidance (e.g., the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent).

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				due to a foreseeable (or actual) decision to object to partake in TOP. References 8. www.abortionreview.org (2019). Statistics briefing (3): Grounds for abortion. Available at: http://web.archive.org/web/20180808011334/http:/www.abortionreview.org/index.php/site/article/963/ [Accessed on 21st May 2019]. BMA, The Law and Ethics of Abortion, November 2014	
British Islamic Medical Association	Guideline	6	17	Muslim patients may freely and wilfully request the inclusion of their spouse or family members in their TOP (or continuation of pregnancy) decision. Healthcare professionals should respect and facilitate this, and not stigmatise women for their decision to include others in their reproductive choice. Healthcare professionals must also not apply pressure on Muslim women to partake in their decision alone, if that is not what they want. Similarly, healthcare professionals should be conscious of third parties seeking to influence the decision of a Muslim patient against her will and should provide adequate safeguarding in such a situation. Healthcare professional should also not stigmatise or judge Muslim women for wanting to continue with their pregnancy based on underlying theological beliefs, even if they do not sit with the personal viewpoints of the healthcare professional involved in that shared-decision.	Thank you for your comment. The recommendations do not state that women need to make this decision alone, but is aimed at reducing the concerns of women that do want to keep the information private. However, this would not limit the woman from sharing any information that she may wish to. It is basic clinical practice for healthcare professionals to be alert to physical or emotional abuse or coercion and therefore no specific recommendations were made on this point as this is covered by professional guidance (e.g., the General Medical Council guidance https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent). The introductory text of the guideline has been amended to make reference to this. The NICE guideline on Patient Experience in Adult NHS Service, which recommendation 1.2.5 refers to, recommends that all patients are treated in a respectful and non-judgemental manner, regardless of their treatment choices. In addition, the Equalities Impact Assessment form published alongside this

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					guideline details how equality issues were considered.
British Islamic Medical Association	Guideline	11	7	Information provision should not only be limited to the experiences of women who have had a TOP but should also include information about women considering TOP (for various reasons), as well as information on the experiences of women who chose to continue with their pregnancy despite initially considering/deciding on a TOP. This is in lieu of the fact that women should be aware of their freedom to change their decision at any time during the process. It is essential that information provision from all healthcare professionals involved in the TOP care pathway is holistic and includes information on the continuation of pregnancy, as opposed to being limited to the experiences and options of the type/time of TOP procedure, and the implications thereafter.	Thank you for your comment. The guideline is for people who have requested an abortion and covers safe and effective abortion care. The alternative options to abortion are outside the scope of this guideline. Women have the right to change their mind and clinicians should follow professional guidance (e.g., the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent).
British Islamic Medical Association	Guideline	12	8	It is essential that healthcare professional involved in TOP-decisions with women first gauge the extent to which a woman wishes to be informed about the intricacies of the process. This is to avoid undue distress to the patient, in what already may be a difficult and sensitive decision.	Thank you for your comments. As with all NICE guidance, this guideline should be read in conjunction with the NICE guideline on Patient Experience in Adult NHS Services which makes recommendations on exploring the patient's preferences about the level and type of information they want. This is cross referenced in recommendation 1.2.5 of this guideline.
British Islamic Medical Association	Guideline	12	16	Muslim women may wish for foetal remains to be buried according to Islamic funeral rites. Healthcare professionals should therefore adequately explain the process of discharging foetal remains and do so in a manner sensitive of	Thank you for your comment. The Human Tissue Authority has guidance on meeting religious or cultural needs relating to the disposal of the pregnancy remains, including Islamic funeral rites, and the right to take remains home. This information has been added to the rationale but it

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				the status that a Muslim patient (and her family) may award to the deceased foetus.	is beyond the scope of this guideline to provide specific guidance on this.
British Islamic Medical Association	Guideline	12	23	It has been shown that there is a higher incidence of foetal anomalies in pregnancies borne to British Muslim women, thought to result from their higher incidence of cousin marriages amongst certain ethnic and cultural groups within the Muslim community [11, 12]. For this reason, consideration of TOP due to foetal anomaly may be more common among Muslim women than the general female population. In this regard, we recommend that: • Pre-natal screening for foetal anomalies should not be withheld from Muslim women, just because they are unsure about whether they would have a TOP. In this regard, all patients have the right to information about their pregnancy, so that they can make as well-informed choices as possible. • The provision of information about the nature of the anomaly, whether it directly causes risk to the health of the Muslim patient during her pregnancy, or the expected responsibility (i.e. hardship) associated with supporting a disabled child is essential. This is because such information forms the basis of the Islamic legal exception permitting TOP in the case of foetal anomaly, thus is likely to be influential to a Muslim patient's decision on TOP due to foetal anomaly. • Muslim patients should be made aware of the support available to them should they wish to	Thank you for your comment. The guideline is for people who have requested an abortion and covers safe and effective abortion care. Therefore, prenatal screening and information about the nature of the anomaly are outside the scope of this guideline. Prenatal screening is covered by the NHS fetal anomaly screening programme (https://www.gov.uk/topic/population-screening-programmes/fetal-anomaly) and information about the nature of the anomaly would be provided by the maternity service/fetal medicine specialist that diagnosed the anomaly. If a woman decides she does not wish to have an abortion she will no longer be cared for by that service, and therefore support for women continuing with pregnancy falls outside the scope of this guideline.

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				continue with a pregnancy involving a foetal anomaly. Healthcare professionals should also engage in discussion about the patient's social support structures in this regard. • In cases of familial diseases, we recommend genetic/diagnostic tests be offered to at-risk, pregnant Muslim women as early as possible, allowing them to consider TOP in good time before the time of ensoulment. References 9. Sheridan E. et al. Risk factors for congenital anomaly in a multiethnic birth cohort: an analysis of the Born in Bradford study. *Lancet*. 2013. 382(9901):1350-9 10. Corry P. C. Consanguinity and Prevalence Patterns of Inherited Disease in the UK Pakistani Community. *Hum Hered*. 2014. 77:207-216	
British Islamic Medical Association	Guideline	15	5	In the case of a surgical TOP, Muslim women, due to various religious or cultural factors, may request a female doctor to carry out their procedure. Some Muslim patients may see this as more important than others. TOP services should therefore attempt, where possible, to facilitate this request, including referral to other TOP providers.	Thank you for your comment. The NICE guideline on Patient experience in adult NHS services, which this guideline refers to in recommendation 1.2.5, recommends that care in all services is tailored to the patients' needs and circumstances.
British Islamic Medical Association	Guideline	16	5	In the context of wanting to preserve (all parts of) foetal remains from a TOP for an Islamic burial, Muslim women may have specific sensitivities about how to handle said foetal remains during an at-home expulsion. In this regard, healthcare professionals should fully explain to the patient	Thank you for your comment. The Human Tissue Authority has guidance on meeting religious or cultural needs relating to the disposal of the pregnancy remains, including Islamic funeral rites, and the right to take remains home. This information has been added to the rationale but it

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				what to expect during an at-home expulsion, as well as the option of medical termination under hospital admission purely for the purposes of more sensitive handling of foetal remains and respectful discharge of said remains to the patient/family thereafter.	is beyond the scope of this guideline to provide specific guidance on this.
British Islamic Medical Association	Guideline	21	4	TOP providers should provide the option of in-house counselling or psychological interventions, as opposed to referring to community mental health services, in the interest of maintaining a woman's confidentiality and providing prompt support.	Thank you for your comment. The committee did not specify where counselling should be provided as some women may prefer to have this within the abortion service as suggested, but others may want independent counselling which has been suggested by other stakeholders. The committee also agreed that, beyond a certain threshold, it may not be in the best interest of the woman to have counselling within the service as they are unlikely to have as much expertise as specialist services. Therefore, the recommendations have been left as 'provide or refer' to give services and women the options of both providing this in house and referring to independent services.
British Islamic Medical Association	Guideline	21	6	Apart from counselling, Muslim women may request access to Muslim chaplaincy services to provide support before, during and after TOP. We recommend that TOP service providers explore links with approved local hospital and community Muslim chaplains and establish a referral pathway for women who request it. It is also essential that both male and female Muslim chaplains are there to listen and offer spiritual and pastoral care without judgment and in a confidential manner, whatever the reason for the	Thank you for your comment. Chaplaincy did not emerge as a theme from the evidence review so the committee did not make recommendations in this area. However, recommendation 1.14.4 has been amended to include 'pastoral support'. The committee discussion section of evidence report O has been updated to reflect this change.

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				TOP, or the week of gestation that the TOP was carried out at.	
British Islamic Medical Association	Guideline	23	15	We, the British Islamic Medical Association, recommend the commissioning of research into the development of culturally and religiously sensitive TOP care pathways for Muslim women. This could include, but is not limited to: • What factors affect a British Muslim woman's decision to terminate her pregnancy? • What barriers, if any, exist to British Muslim women accessing TOP services? • Do British Muslim women's experience of TOP services evidence that they are provided in a way which reflects and accounts for their concerns, beliefs and values? To what extent would the sensitivity of the 18-21 week foetal anomaly scan be affected, were it to be offered earlier at 14-16 weeks to Muslim women, allowing them time to consider TOP (before 19 weeks post-LMP) for other foetal anomalies not screened for during the early pregnancy (10-14 week) scan?	Thank you for your comments. NICE guidelines are only able to make research recommendations if an evidence review is conducted but limited or no evidence is identified by the searches. Therefore, it is not possible to make research recommendations about factors that affect the decision to have an abortion or experiences of abortion services that are not related to accessibility and sustainability of abortion services, or the sensitivity and timing of prenatal screening as the guideline did not include review questions in those areas. The guideline reviewed evidence for factors that help or hinder the accessibility and sustainability of abortion service. However, no evidence was identified for barriers to accessing abortion services that was specific to British Muslim women. The committee did not prioritise research in this area as there was sufficient evidence for the factors that help or hinder accessibility of abortion services to inform recommendations that should be beneficial to all women and there are many groups of women that may have additional, differing factors or complications to accessing services.
British Pregnancy Advisory Service (BPAS)	Guideline	General	General	It is important to note that although it seems clear that this guideline is aimed at provision in England, it will influence provision in Scotland and Wales, as well as further afield in areas with newly revised laws such as the Isle of Man and Gibraltar. Given the different forms of provision in Scotland	Thank you for your comment. The committee recognises the variation in practice across the UK, but NICE guidelines apply to England and therefore are written with English law and practice in mind. Decisions on how NICE guidance applies in Scotland and Wales are made by the devolved

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				and Wales, potential issues with services should be included in this document – particularly choice of option and provision up to the legal limit where neither nation provides Ground C ToPs up to 23+6	administrations, who are often involved and consulted with in the development of NICE guidance.
British Pregnancy Advisory Service (BPAS)	Guideline	General	General	We believe it is important to make clear in the introduction to the Guidance that the RCOG 2011 guidance on Care for women requesting an induced abortion should be used to fill gaps left by this guidance. This is particularly the case with foeticide (which really would benefit from being included in this guidance wholesale)	Thank you for your comment. The introductory text has been amended to provide information about additional relevant guidance, including the RCOG 2011 guidance. The committee did not prioritise feticide during protocol development so the committee were unable to make recommendations in this area. The evidence reports for medical termination of pregnancy between 10 and 24 weeks gestation (Evidence Report J) and after 24 weeks gestation (Evidence Report L) acknowledge the RCOG 2010/2011 guidance that recommends feticide after 21+6 weeks' gestation. This information has also been added to the relevant rationale sections to explain why recommendations were not made.
British Pregnancy Advisory Service (BPAS)	Guideline	4	6	The inclusion of 'referral' is important and useful because it ensures that women are not expected to be able to know sufficient amounts about local provision in order to access care which is not (as standard) provided via usual primary care pathways – thus reducing the likelihood of unnecessary delays and/or confusion.	Thank you for your comments.
British Pregnancy Advisory Service (BPAS)	Guideline	4	9	BPAS strongly endorses the inclusion of self-referral as an 'offer' recommendation. Our service is largely available (depending on contract) via	Thank you for your comment. The committee discussion in evidence report A highlights that, due to some services currently requiring a referral,

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				both self-referral and referral from GPs, sexual health clinics, and other local services. In 2017, roughly 81% of clients in England came to us via self-referral, with only 16% being referred by GPs. Based on these figures, it is clear that women prefer self-referral as a method. We are aware, however, that there are some areas of NHS provision where a GP signature on an HSA1 is needed to proceed with treatment owing to a lack of doctors available for signature at the point of treatment. There are also some services, particularly in Scotland and Wales, where referral is the norm. Requiring self-referral will encourage these services to put adequate procedures in place to find signatories at the point of treatment and not force women to attend multiple appointments with different doctors – reducing delays and pressure on primary care services.	changes may be needed to commissioning and service organisation to enable self-referral.
British Pregnancy Advisory Service (BPAS)	Guideline	4	11	BPAS endorses this provision which goes no further than law as a result of Greater Glasgow Health Board v Doogan or existing GMC provisions. Its inclusion is important to ensure that healthcare professionals are aware of their obligations to patients seeking abortion care even if they themselves do not provide the service or have a personal conscientious objection to provision. We are aware of reports from patients of misleading information being provided by the GP, including misleading descriptions of the law re: gestational limits and waiting periods, inaccurate descriptions of procedures designed to	Thank you for your comments.

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				dissuade women from accessing care, and refusal to provide women with information to allow them to self-refer. All guidelines should make clear that attempts by medical professionals to dissuade access to care based on personal beliefs are inappropriate.	
British Pregnancy Advisory Service (BPAS)	Guideline	4	13	We recommend that upfront funding is an 'offer' rather than a 'consider' point and recommend including an additional bullet point about making information about the scheme widely available. As a charitable provider, BPAS is asked to provide upfront funding to women even where our contract does not have the provision for us to recharge the commissioning body, which is the case approximately 50% of the time. We are aware that this ability to fund upfront is not the case with many NHS services where women may be forced to travel sizeable distances to access even early treatments, and that women do put off attending services, particularly when later in pregnancy, to enable them to save up money for travel tickets or accommodation. For instance, many English CCGs in rural areas where travel is likely to be involved in care do not provide upfront funding even for later gestations, few health boards in Wales provide up-front funding for patients who have to travel outside their area for a termination beyond 15 weeks (the highest surgical gestation offered in Wales), and women in Scotland report a lack of knowledge about funding schemes where they have to travel for procedures beyond 18	Thank you for your comment. The committee were not able to make a stronger recommendation for upfront funding based on the evidence available. An additional point has been added to this recommendation to say that commissioners should make information about any upfront funding available.

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				weeks. Owing to the specialised nature of later procedures, it is unlikely that all women will have a local service up to the legal limit and thus many women will be required to travel. Lack of up-front funding causes delays, particularly for vulnerable women, and with the delay the risk of experiencing a negative side-effect increases. A 2014 paper by Purcell, Cameron et al. *Access to and Experience of Later Abortion: Accounts from Women in Scotland* details women's issues with funding travel to England for abortion beyond 20 weeks – highlighting not only the need for up-front funding but the need for making information about these schemes easily accessible.	
British Pregnancy Advisory Service (BPAS)	Guideline	4	21	BPAS supports the inclusion of ideal maximum waiting times to ensure that women are able to access treatment without undue delay and with the lowest risk of negative side-effects as possible. With regards to the current drafting we have a few comments: • Use of the word 'provide' places an onus on providers that is not reflective of women's choices about treatment. We recommend replacing the word 'provide' with 'offer' – reflecting the need for a waiting time target but recognising that women may opt for an appointment outside the ideal waiting time • We believe that the division between assessment and procedure is a false separation. The vast majority of providers	Thank you for your comment. The recommendation is not trying to introduce a separation between assessment and treatment or introduce an enforced waiting period. The rationale has been amended to make it clear that same day services can be provided where possible. However, it is not always feasible to provide same day services due to the type of procedure preferred and it can take time to determine medical eligibility. The committee did not think it was appropriate to combine the time frames to offer assessment and treatment within 2 weeks as this may lead to long waiting times with early medical abortions being provided at the end of this time frame. The committee agreed that it was more appropriate to specify the time between assessment and termination, compared with

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				already offer same-day treatment for some forms of ToP (primarily Early Medical Abortion, which accounts for more than 65% of all abortion procedures). Dividing the waiting times for assessment and treatment is likely to encourage commissioners to set KPIs based on this false separation, meaning women would be unable to access the same-day treatments they are currently able to, and in fact produce an enforced waiting period between assessment and treatment. In order to enable flexibility with same-day procedures whilst ensuring no overall increase in the recommended waiting times, we recommend removing the bullet points and completing the previous sentence with "offer assessment and treatment within 2 weeks of initial contact." If the committee opts not to combine assessment and treatment waiting times, we recommend rewording 'assessment' in the second bullet point to 'decision to proceed' as some women may choose to have further pre-abortion counselling or require additional support in advance of making a decision which would make an enforced target inappropriate at this point.	decision to proceed and termination, as evidence shows the majority of women are certain of their decision to proceed at the time of the assessment (Cameron 2013). This information is included in the discussion for evidence report A. The committee agreed that the language in recommendation 1.1.6 makes it clear that this is an ideal time frame, not an absolute requirement and that recommendation 1.1.7 gives women the option of waiting longer if they would prefer this.
British Pregnancy Advisory Service (BPAS)	Guideline	5	3	Waiting times are often negatively impacted by delayed referral – particularly where services at different gestations are provided by different	Thank you for your comment. This guideline aims to reduce delays by streamlining abortion services. However, it was not possible to make

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				providers. For example a number of health boards in Scotland have a requirement that women who are beyond the local limit have their case referred by a consultant, even when they self-refer to BPAS. This leads to unacceptable delays when women are legally and contractually able to access care elsewhere, and can have a particular impact on women later on in pregnancy. We are also aware of a handful of cases where a referral has been refused, despite the local consultant having no role in obtaining consent for treatment. We recommend that an additional 'offer' point is added to require referral without delay where treatment cannot be provided by local services (such as in the case of later gestations).	recommendations about referrals in Scotland as this is outside of the scope of NICE guidelines. Decisions on how NICE guidance applies in Scotland and Wales are made by the devolved administrations, who are often involved and consulted with in the development of NICE guidance.
British Pregnancy Advisory Service (BPAS)	Guideline	5	4	BPAS strongly endorses the provision not to require compulsory counselling or a 'cooling-off' period. This is not provided for in existing abortion law in Great Britain and cause unnecessary and harmful delays to women who have already considered their decision to proceed with a termination. Counselling and cooling-off periods have both been considered in Parliament in recent years and no resulting changes have been made to the Abortion Act 1967. It would be inappropriate for NICE guidelines to recommend changes in long-standing practice in these circumstances.	Thank you for your comments.
British Pregnancy Advisory Service (BPAS)	Guideline	5	7	BPAS endorses the provision of assessments by telephone or video call which will enable women who have work or caring commitments, or are	Thank you, the recommendation has been amended from 'consultations' to 'assessments' in line with your comment.

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				located remotely, to receive an assessment without the need to travel to a clinic. This is particularly true for women who may be travelling long distances for later or specialist procedures. We recommend that 'consultations' is changed to 'assessments' to be in line with the wording of previous recommendations – and that wording throughout the guideline should be standardised to refer to 'assessment' for the initial discussion.	
British Pregnancy Advisory Service (BPAS)	Guideline	5	9	BPAS endorses the inclusion of a specific recommendation that services do not need to be provided in hospitals and can be provided in the community. This is already the case across much of England but is not the case in some NHS services, in Wales, or in Scotland. The result of this is that in some areas, women are forced to travel greater distances in places where public transport is not always accessible – causing delays and making access more difficult. We recommend changing the wording to 'reflecting the needs of the local population' to make clear that it is unlikely that the needs of any local population will be to have only a hospital-based service.	Thank you for your comment, the recommendation has been amended to 'to meet the needs of the local population'.
British Pregnancy Advisory Service (BPAS)	Guideline	5	13	BPAS strongly endorses the inclusion of this recommendation	Thank you for your comments.
British Pregnancy Advisory Service (BPAS)	Guideline	5	15	BPAS endorses the inclusion of this recommendation to improve understanding and experience of abortion provision in England. 2/3rds of abortions in England and Wales are provided by the independent sector which enables	Thank you for your comments.

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				women to receive specialised care but which can mean that other health professionals are not familiar with services and procedures which 1 in 3 of their female patients will experience.	
British Pregnancy Advisory Service (BPAS)	Guideline	5	21	BPAS strongly endorses the inclusion of this recommendation which will mean that more specialist trainees receive full training on an opt-out not opt-in basis. Under current provisions, we are concerned that trainees do not currently receive the training they need and that abortion care, particularly for later gestations, is a small speciality highly removed from standard training, which puts the pipeline of qualified practitioners under threat for the future.	Thank you for your comments.
British Pregnancy Advisory Service (BPAS)	Guideline	6	2	BPAS strongly endorses the inclusion of this recommendation which is particularly relevant in areas where there is no hospital provision and all abortion care is outsourced. We also strongly endorse the idea that NHS services should accept trainees for the purpose of gaining experience – a scheme which BPAS runs but which, in areas where the NHS Is the primary provider, trainees may find it harder to get the requisite experience of a ToP service.	Thank you for your comments.
British Pregnancy Advisory Service (BPAS)	Guideline	6	5	BPAS supports placing the onus on commissioners rather than providers for the provision of specialist centres as lack of funding and lack of combined commissioning is the main	Thank you for your comments. On reflection, as the specification and commissioning framework for specialist abortion services is currently being developed by NHS England, we have amended 'commissioners should ensure specialist

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				block to providing highly specialised, and thus expensive, services	centres…' to 'specialist centres should…' to make a distinction between the commissioning framework for this recommendation and other references to commissioners within this guideline.
British Pregnancy Advisory Service (BPAS)	Guideline	6	10	BPAS recommends including another bullet point in this recommendation which includes the provision of a Central Booking Service for specialised services – enabling NHS, independent providers, and women themselves to book for specialist treatment. BPAS currently runs a Specialist Placement Team which finds hospital appointments for women who cannot be treated in stand-alone clinics (this service primarily involves clients who have presented at bpas but also receives some external referrals) but this service is not commissioned and is unfunded.	Thank you for your comment. No evidence was identified that centralised booking services are effective, so the committee did not make recommendations in this area.
British Pregnancy Advisory Service (BPAS)	Guideline	6	15	BPAS endorses this recommendation	Thank you for your comments.
British Pregnancy Advisory Service (BPAS)	Guideline	6	21	Query – is this recommendation necessary? Are services allowed to share information with other healthcare providers eg via letters, about procedures without obtaining permission from the patient directly under GDPR rules? Do they not have a higher level of confidentiality required as a result of it being healthcare information?	Thank you for your comment. The recommendation was made based on evidence identified in evidence report A that showed that women were concerned about their privacy, reactions and judgements from others, and the need to disclose their abortion to unwanted people. Further, the committee were aware of ongoing discussions about whether or not information about an abortion should be shared with a patient's GP.
British Pregnancy Advisory Service (BPAS)	Guideline	7	2	BPAS strongly endorses the inclusion of this recommendation as an accurate reflection of scientifically-proven facts. It is important to include	Thank you for your comments.

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				this is the guidelines owing to myths that are repeatedly perpetuated by anti-choice organisations which are not grounded in high-quality, high-volume research but which many women have heard either through their own searches on the internet or as rumours from friends or family. These myths are also written in leaflets that are distributed by anti-choice groups outside abortion clinics across the UK – 1 in 10 of which in England and Wales have had protests outside at least once in the past two years. The pro-active provision of this information ensures that women are making informed decisions based on high quality clinical evidence which is endorsed by RCOG, the World Health Organisation, and medical and scientific bodies from around the world.	
British Pregnancy Advisory Service (BPAS)	Guideline	8		**Table, right column, line 3** Osmotic dilators are described as 'medicated sticks' which is incorrect as they are not medicated. Alternative wording should be found.	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists. The text has been amended so that osmotic dilators are referred to as 'matchstick-sized rods (called absorbent dilators)' in the PDA.
British Pregnancy Advisory Service (BPAS)	Guideline	10		**Table, right column, line 3** The week descriptor is "Between 13+0 and 23+6 weeks". According to the *Clarification of time limit for termination of pregnancy performed under Grounds C and D of the Abortion Act 1967* of 28 March 2019 issued by the Chief Medical Officer,	Thank you for your comment. This table has been replaced by a patient decision aid that will be published alongside the final guideline. However, a footnote has been added with this clarification to the recommendation on choice of procedure

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				evacuation subsequent to feticide can be performed after the completion of the twenty fourth week of pregnancy. This aspect of a surgical abortion should not, therefore be limited to 23+6.	(1.6.1), and an explanation has been added to the rationale section.
British Pregnancy Advisory Service (BPAS)	Guideline	12	5	BPAS endorses the requirement to 'ask women' about contraception to improve woman-centred care and not require that all women have contraceptive counselling. For some women, contraception counselling may not be appropriate (in the case of a planned pregnancy, or TOPFA), and for others they may be happy with their choice of contraception. This formulation ensures that any woman who wants to discuss her contraceptive options can, without being compelled to.	Thank you for your comments.
British Pregnancy Advisory Service (BPAS)	Guideline	12	10	On the question of movement, there should be clarification about how this refers only to the second trimester	Thank you for your comment. The committee agreed that this would only refer to later gestations which is why the recommendation says 'whether' there will be any movement. However, the committee agreed this did not need specifying as it will be the responsibility of the clinician to provide this information where relevant.
British Pregnancy Advisory Service (BPAS)	Guideline	12	16	BPAS recommends amending the wording to reflect the Human Tissue Authority to ensure that this applies equally throughout pregnancy and regardless of how women wish to refer to their pregnancy – so changing 'handling fetal remains' to "management and disposal of pregnancy remains"	Thank you for your comment. This has been amended as suggested.

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British Pregnancy Advisory Service (BPAS)	Guideline	12	20	The primary concern of many women BPAS treat for TOPFA is not that their local hospital was unable to provide any method for TOPFA, but that they were only able to provide a late medical and the women preferred a surgical option. BPAS therefore recommend amending this recommendation to include, after 'maternity setting', "or a choice of method for termination of pregnancy for fetal anomaly cannot be offered,"	Thank you for your comment. This has been amended to 'if a woman cannot have her preferred method of abortion in the maternity service'.
British Pregnancy Advisory Service (BPAS)	Guideline	12	23	This bullet point is unclear as to whom it refers. ToP providers are not the service that will be providing more information about the anomaly (post-termination). We assume, based on ordering, that this refers to a post-mortem after TOPFA rather than information prior to a decision to proceed with TOPFA but this is once again unclear. These recommendations should be clarified.	Thank you for your comment. Information about the anomaly should be provided by the maternity service or fetal medicine specialist that diagnosed the anomaly. Recommending ongoing communication between services should facilitate this. The committee agreed it was not appropriate to define the timing of this as women may want further information both before the abortion and post-abortion.
British Pregnancy Advisory Service (BPAS)	Guideline	13	3	Table 1 segregates medical abortion into 'before 10+1' and 'after 10+0'. The cut-off point for Early Medical Abortion would therefore appear to be 70 days (in line with international best practice), but this anti-D point appears to shift the cut-off to 69 days which is not aligned with a change of method (including ability to self-manage expulsion at home). We recommend that throughout 1.3, dates are aligned with Table 1 to refer to after 10+0 and before 10+1.	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. However, the dates in the anti-D section have been amended to be consistent with those in the early medical abortion section.

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British Pregnancy Advisory Service (BPAS)	Guideline	13	9	BPAS endorses the inclusion of this point to encourage NHS providers to allow for point of care testing and anti-D prophylaxis outside the standard transfusion service which adds delays to women's treatment by requiring them to return for more than one appointment. As stated on p31, point of care testing would be in line with current provision in the independent sector.	Thank you for your comments.
British Pregnancy Advisory Service (BPAS)	Guideline	13	17	BPAS endorses the initial proposal that antibiotic prophylaxis should not be provided to women undergoing a medical termination. However, the proposal to provide routine antibiotic prophylaxis to women 'if they have an increased risk of sexually transmitted infections' is unclear and unsupported by international evidence. In the first instance it is unclear what 'increased risk' refers to, what tool or method is being used to assess risk, and what degree of risk requires the introduction of antibiotic prophylaxis. Secondly, sexually transmitted infections are only one aspect of the potential for post-abortion infection, meaning the focus on risk of STI is unwarranted. In a climate of responsible antibiotic stewardship, it is unjustifiable to provide antibiotic prophylaxis to large numbers of women who are at a low risk of infection on the basis of minimal evidence and outside similar international guidelines including those provided by the World Health Organisation in their 2014 Clinical Practice handbook for Safe Abortion. We suggest that this point is amended to recommend that antibiotic prophylaxis is not	Thank you for your comment. The recommendations for antibiotic prophylaxis for medical abortion have been amended to say they should not be routinely given rather than given to those at risk of STIs. The committee discussion in evidence report D and the rationale and impact has been updated to reflect these changes.

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				provided to women who are having a medical termination of pregnancy.	
British Pregnancy Advisory Service (BPAS)	Guideline	13	19	In line with our previous comment, we believe that this provision should be removed. However, if the Committee disagree with our comment 29, the proposals for 'antibiotic prophylaxis' both at 1.4.2 (medical termination) and 1.4.5 (surgical termination) do not reflect true prophylaxis but instead are the same as the BASSH-recommended treatment dose and course for uncomplicated chlamydia infection. Antibiotic prophylaxis should be based on risk of procedure-related infection and not on an (unsupported) expectation that women presenting for termination are likely to have chlamydia. Treatment level doses/courses are also not without side-effects for women attending for treatment, with Evidence Review D recognising that a 7-day doxycycline course results in higher rates of severe nausea, severe vomiting, and vomiting lasting more than 1 day. In a climate of responsible antibiotic stewardship, it is unjustifiable to provide treatment doses of antibiotics to potentially tens of thousands of women. We recommend that these doses are reviewed and reduced.	Thank you for your comment. There was not enough evidence to support recommending a specific regimen for antibiotic prophylaxis using prophylactic as opposed to treatment doses. However, the committee have recommended that if doxycycline is being used, a 3-day course is considered. The research recommendation has been expanded to include an investigation of all possible prophylactic regimens (see appendix L in evidence report D). The committee discussion in evidence report D and the rationale and impact has been updated to reflect these changes.
British Pregnancy Advisory Service (BPAS)	Guideline	14	9	See comment 30 – the recommended dose and course of antibiotics reflect treatment levels and not true prophylaxis. We recommend that these are reviewed and reduced – to be in line with	Thank you for your comment. There was not enough evidence to support recommending a specific regimen for antibiotic prophylaxis using prophylactic as opposed to treatment doses.

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				prophylaxis provided for surgical treatment of pregnancy loss. Evidence Review D recognises on page 17, line 32 on the basis of the Lichtenberg study that there is no clinical difference in infection outcomes between 3-day and 7-day courses of doxycycline, but the guideline then proceeds to opt for the higher treatment level without evidence to support the decision. In addition, the American College of Obstetricians and Gynaeologists' 2018 interim update on early pregnancy loss recommends a single preoperative dose of 200mg of doxycycline for women undergoing surgical management of pregnancy loss in the first trimester. There should be no expectation that women presenting for ToP rather than missed miscarriage are more likely to require treatment doses of antibiotics for surgical risk as opposed to chlamydia treatment.. Finally, both testing for chlamydia and providing full treatment doses as a prophylactic is a significant excess cost to commissioners.	However, the committee have recommended that if doxycycline is being used, a 3-day course is considered. The research recommendation has been expanded to include an investigation of all possible prophylactic regimens (see appendix L in evidence report D). The committee discussion in evidence report D and the rationale and impact has been updated to reflect these changes.
British Pregnancy Advisory Service (BPAS)	Guideline	14	19	The use of recommendations from VTE guidance is highly likely to over-estimate the risk of VTE in relation to termination of pregnancy and not accurately reflect the needs of women being treated. The NICE VTE guidance is focused on 'reducing the risk of **hospital-acquired** deep vein thrombosis or pulmonary embolism'. A tiny proportion of women who undergo ToPs in any given year are inpatients in hospital – largely	Thank you for your comment. The NICE guideline referred to covers hospital acquired VTE. However, the risk assessment is concerning all pregnant women, not just those who are inpatients. However, as explained in the committee discussion in evidence report E, this risk assessment may overestimate risk as it is a risk assessment for term pregnancies, or for women continuing pregnancies to term, where

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				being mobile, having either no or short-term deep sedation or general anaesthesia, and walking out of the clinic within a few hours of treatment. A 2013 BMJ study by Sultan et al. *Risk of first venous thromboembolism in pregnant women in hospital: population based cohort study from England* studied more than 200,000 women between 1997 and 2010 found that admittance to hospital during pregnancy was associated with a 17.5-fold increase in risk of a VTE event. Evaluating women in line with provisions specifically for hospital inpatients does not accurately reflect the risk posed to women undergoing terminations in the first two trimesters, is therefore unlikely to provide optimal clinical outcomes, and is likely to result in a large number of women being provided unnecessarily with LMWH. Additionally, this risk assessment is largely related to women who are admitted to hospital late in pregnancy or who spend time in hospital part-partum – skewing the levels of risk appropriate to women having abortions in the first and second trimesters. A 2018 Lancet Haematology study by Liu et al. *Venous thromboembolism after induced abortion: a population-based, propensity-score-matched cohort study in Canada* found that while the rate of VTE within 42 days of an induced abortion was 30.1 per 100,000 compared to 13.5 per 100,000 non-pregnant women, the HR was 0.16 when compared with women in the live birth cohort whose risk of VTE in the 42 days post-	coagulation factors will be higher than for women having an abortion at earlier gestations. On reflection, and in response to comments from stakeholders, the committee have removed the recommendation which cross-referred to this risk assessment. The committee discussion in evidence report E has been updated to reflect this change. However, as this question was concerned with thromboprophylaxis for women who have been identified as requiring it, and not risk assessment for VTE, the committee were not able to make recommendations about who may need thromboprophylaxis.

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				partum was 184.7 per 100,000. A 2011 Sultan et al. study *Risk of first venous thromboembolism in and around pregnancy: a population-based cohort study* found that while the risk of VTE in the third trimester was 6 times higher than outside pregnancy and the first 6 weeks post-partum conferred a risk 22 times higher than outside pregnancy, both the first and second trimesters conferred little additional risk. The fact that there are no additional related studies in Evidence Review E should highlight that this is a recommendation in search of a problem, and whose contents are unsupported by evidence. This is also likely to provide wider issues with safety and adherence where large numbers of women are discharged with a requirement to administer injectable drugs, alongside syringes which they may not have appropriate means to dispose of. Given the large proportions of women who opt for EMA (65% of all patients), this recommendation would require women in this bracket to return to the clinic post-abortion for an additional appointment, which increases barriers to access particularly for vulnerable women. Even for those women who are not expected to attend twice as many appointments as currently necessary, the amount of time needed for an appointment will increase which will have a negative impact on women with work or caring responsibilities – which the women are disproportionately likely to have given that one of	

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				the risk factors in the RCOG document is parity of 3 or more. It is also important to note that the nature of providing LMWH to hospital inpatients is that they are monitored on a ward with medical professionals easily available in case of negative side-effects such as LMWH-induced major bleeding. Women who are self-managing administration post-termination do not have this medical support and could suffer major side-effects alone at home. Based on clients BPAS has treated in the last year, 869 women had a score of three or more on the RCOG risk assessment before medical or additional history was taken – about 1% of our total client base. This indicates that the proposals could result in up to 2000 women a year in England and Wales being prescribed LMWH. 62% of these clients had same-day EMA treatments, meaning they would be required to return for additional appointments for LMWH provision.	
British Pregnancy Advisory Service (BPAS)	Guideline	15	5	BPAS strongly endorses this recommendation, allowing women to make basic choices about their treatment. This is particularly relevant in areas such as Scotland or Wales where surgical procedures are less available, or where contracted providers are not able to provide late medicals for women who either prefer them or who are unable to undergo a surgical procedure owing to contraindications.	Thank you for your comments.

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British Pregnancy Advisory Service (BPAS)	Guideline	15	10	BPAS endorses this recommendation, in addition to recognising that new services such as those in the Republic of Ireland are not using ultrasounds as a matter of course and ultrasounds are not recommended for medical terminations by the Royal College of Obstetricians and Gynaecologists.	Thank you for your comments.
British Pregnancy Advisory Service (BPAS)	Guideline	16	3	The title of this section refers only to expulsion at home and not, as is now legal throughout the UK, Early Medical Abortion at Home. Restricting this recommendation only to expulsion at home ignores the major development in abortion law in the past couple of years and is likely to result in services that do not already allow women to take misoprostol home with them not developing this service – which is essential for better patient experience. We recommend that this section is rolled into 1.9 given the same time limit and that 1.9 then includes two separate recommendations on expulsion at home and medical termination at home. This would mean an additional 'offer' point being added to allow women to take misoprostol home with them in line with the authorisation of the relevant Secretary of State (the provisions differ between England, Scotland, and Wales, and there are no restrictions in Northern Ireland so the guideline should not introduce limitations that are currently governed by Chief Medical Officer guidance).	Thank you for your comment. The evidence review that these recommendations are based on addresses the question of the gestational age at which it is safe to pass a pregnancy at home. This may happen after taking misoprostol at home or in the clinic, depending on gestational age and the preferences of the woman. The evidence review did not address the gestational age at which misoprostol can be taken at home, as this is specified in the in the 2018 Secretary of State approval order. Therefore, the committee agreed that these sections should be kept separate to not confuse this issues of home expulsion and home use of misoprostol. However, the recommendations have been amended to clarify that women up to 9+6 weeks gestation can take the misoprostol at home (or in clinic/hospital) and expel the pregnancy at home but women at 10+0 will have to take the misoprostol in clinic before expelling the pregnancy at home.

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British Pregnancy Advisory Service (BPAS)	Guideline	16	8	The phrasing of this section is unclear and needs clarification. The provision on line 11 that interval treatment is offered between 9+1 and 10+0 seems to exclude the possibility of offering interval treatment to women before 9+1, which we know women do still opt for as they would rather have reduced side-effects but either do not want to take the misoprostol home with them or are not able to under the rules laid out in the various Secretary of States' authorisations. In the last year, about 7% of women having an EMA with bpas before 9+1 (3300 clients) opted for interval dosing in-clinic. We would recommend removing 'between 9+1 and 10+0 weeks' gestation' from line 11. This would mean that all women could be offered interval and only women up to 9+1 are offered simultaneous treatment. In line with our comment 35, provisions for expulsion at home and EMA at home should be included in this section.	Thank you for your comment. "Between 9+1 and 10+0 weeks' gestation" has now been amended to 'up to and including 10+0 weeks gestation' to clarify that interval treatment should be offered to all women having early medical abortion. The committee agreed that these sections should be kept separate to not confuse this issues of home expulsion and home use of misoprostol, as the evidence for home use of misoprostol was not reviewed as part of this guideline.
British Pregnancy Advisory Service (BPAS)	Guideline	16	13	BPAS endorses the recommendation that women should be offered a choice of EMA method	Thank you for your comment.
British Pregnancy Advisory Service (BPAS)	Guideline	18	7 - 15	We have a number of serious concerns about the contents of section 1.12 and have sorted them into bullet points to make assessment easier. • We are concerned that this recommendation (1.12.1) has been included as an 'offer' point despite there being little rigorous evidence to support it. The Evidence Review uses as its measurement criteria cervical trauma and	Thank you for your comment. It is incorrect that there was only a benefit of cervical priming for ease of procedure. Ease of procedure was not included in this review (but was included in the evidence review for cervical priming between 14 and 24 weeks, see evidence report M). However, there was good evidence that cervical priming reduced the risk of incomplete abortion and the force needed to dilate the cervix for women having

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				uterine perforation, pre-operative expulsion, ease and duration of procedure, and patient acceptability. The only aspect of these four measurements that is positively affected according to the evidence is ease of procedure. There is no increase in serious side-effects (cervical trauma, uterine perforation, pre-operative expulsion) when cervical priming is not used, and patients do not report higher levels of unacceptability – indeed the side-effects of misoprostol would indicate that larger numbers of women may well experience higher levels of nausea, vomiting, and diarrhoea • World Health Organisation guidance suggests 12-14 weeks is the point at which priming should be used, and is quoted in RCOG's 2011 Care of women requesting induced abortion guidance • Compulsory cervical prep before 14+0 would affect tens of thousands of women. England and Wales are on a completely different scale to Scotland where cervical prep is the norm – where there were 1,994 surgical terminations in Scotland in 2017, there were more than 66,000 in England and Wales, nearly 85% of which took place before 14 weeks (55,471). • This recommendation is out of line with current practice in England including both BPAS and Marie Stopes. In the past year,	an abortion before 14 weeks. Incomplete abortion was a critical outcome for this evidence review and can very distressing for women. Therefore, the committee agreed it was appropriate to offer cervical priming to all women. The cervical priming regimens have been selected to minimise the time interval between priming and abortion, to reduce duration of symptoms for the women, in recognition of the fact that many women will need to travel, and to minimise burden on services. The evidence for mifepristone was very limited, as explained in the rationale and the discussion in evidence report M. Therefore, misoprostol was recommended in preference to mifepristone. The evidence for the effectiveness of osmotic dilators before 14 weeks was not reviewed as this is not normally done in practice; therefore, it would not be possible to recommend dilators as an alternative at this gestation. The resource impact section has been revised and costs around misoprostol and mifepristone reduced to only include the drug costs and avoid double counting. We would expect there to be an increase in costs but significantly less than £5.2m. Under the revised costs, we would expect the total cost to be significantly less than £1 million. This also does not cover costs savings from reduced adverse events, such as incomplete terminations. As above the relevant text and table have been edited to make this clearer.

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				BPAS has provided nearly 17,500 surgical terminations prior to 14 weeks. Only half of these women received cervical priming (8800). These figures are even more stark before 10 weeks where more than 80% of women received no cervical priming. A change to practice along these lines of the draft guideline would mean tens of thousands of new women across all providers being required to receive cervical priming and spend additional time in clinics – placing additional pressure on surgical services and worsening patient experience. • There would be a sizeable cost of implementation based on costs provided in Evidence Review M – £5.2m to provide prep to tens of thousands women who don't already receive it and this is noted to be an underestimate of cost of provision within the NHS • There is a recognition in the evidence review that "There would need to be either an increase in staffing or a reduction in the capacity and number of terminations of pregnancy that could be given." In short, this would be a huge and costly disruption to service with no reduction in serious side effects and improvement in only one monitored outcome (ease of procedure)	

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				• In addition, there is no justification in literature for preferring miso over mife where mife has fewer side-effects, can be self-administered at home in advance, and similarly improves outcomes for doctors. We would like to see mifepristone and misoprostol are given equal weight as pharmacological primers, and dilators mentioned as an alternative for women who are unable to receive mifepristone or misoprostol. At the very least, it should not be caveated by only considering if misoprostol 'cannot be used'. In the last year, 367 BPAS clients before 14 weeks received mifepristone rather than misoprostol as cervical prep, and several women received dilators or a combination including dilators. ➢ We recommend amending this section and section 1.12.3 to reflect WHO guidance on the use of cervical priming from 12-14 weeks onwards by changing the cut-off point to 12+0 weeks The recommendations for cervical priming up to 12+0 should be amended to 'consider offering, particularly where risk factors for cervical injury or uterine perforation exist,' and include an additional provision for dilators where neither mifepristone nor misoprostol can be used	
British Pregnancy Advisory Service (BPAS)	Guideline	18	21 on	• We are deeply concerned by the 'offer' recommendation in 1.12.3 for dilators, in	Thank you for your comment. On reflection, and in response to comments from stakeholders the

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				addition to the 'consider' point for overnight insertion for women from 14+0 onwards. This proposal would be bad for women, highly destructive for the limited services that provide later surgical abortions, and is unsupported by evidence. The evidence review recognises this when it says 'The committee were unsure whether the benefits of inserting osmotic dilators the day before the termination, compared with the same-day, would outweigh the negative impact this may have on women and services.' • The recommendations are out of step with current provision which is done by very few providers – it does not reflect practice in either BPAS or Marie Stopes which account for around 90% of post-14 week surgical procedures in England and Wales • In the past year, bpas has performed 5523 surgical ToPs between 14+0 and 24+0 – which usually accounts for about half of the surgical procedures performed at this gestation. Only 1683 of the women treated received cervical priming in line with the 'offer' proposal in this guideline (dilators alone). Only a further 509 women received dilators as part of combination cervical priming. In other words, of the 5523 women treated in the last year, 3331 women (60%) received only	committee agreed that: 1) between 14+0 weeks and 16+0 weeks, clinicians should consider using osmotic dilators, mifepristone or misoprostol; 2) between 16+1 and 19+0 weeks clinicians should consider using osmotic dilators of misoprostol and 3) to offer osmotic dilators from 19+1 weeks, as there was no evidence to recommend an alternative after this time point. The committee recommended that overnight dilators are considered, not that they have to be used. The committee discussed the impact of overnight dilators on both women and services and that this may not always be possible. The rationale and the committee discussion in evidence report M have been updated to reflect these changes.

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				pharmacological priming which is not provided for in the guideline unless women decline dilators. • Further, only about a quarter of women having surgical ToP after 14+0 with bpas in the last year will have received overnight dilators. Placing overnight dilators for all women from 14+0 on would require an additional 4000 appointments a year for bpas clients alone, which are simply not available in the existing system in terms of staffing, funding, or clinic capacity. At a base level, it would remove an entire day of later surgical lists because the clinics are not open seven days a week and surgical lists could not run the day after a closed day because of the need to fit overnight dilators. • The evidence for compulsory dilators from 14+0 is not apparent. Studies in the Evidence Review which compare pharmacological and dilators at 14 weeks study only 134 women. They find no difference in baseline cervical dilation, no difference in cervical trauma, no different in uterine perforation rates, no different in pre-operative expulsion, no difference in duration of procedure. The only clinically important difference to favour dilators was the rating of difficulty assigned by doctors. Meanwhile, women were less likely to choose the same process again if they	

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				had dilators compared to miso or mife, indicating a negative patient preference for dilators. These studies are small scale and the Evidence Review makes clear they are very low or low quality. Furthermore, the additional findings make clear that there are no sizeable negative side-effects even where doctors rate their procedures more difficult. • The disclaimer buried in the evidence review is unacceptable – "Further, needing to attend another appointment the day before the termination to insert osmotic dilators will increase the burden and duration of treatment for women and place additional demand on services." This recommendation will cause delays in a service which is already under pressure and where some women are unable to access abortions at later gestations • The Evidence Review attempts to justify this additional demand on services by arguing that 'the number of women have a surgical termination during the second trimester is small'. 10,710 women had a surgical abortion between 14+0 and 23+6 in England and Wales 2017 – more than 200 women a week. Nearly all of these 200 women a week are seen by one of two providers operating out of ten clinics around the country. These 10,000 women are disproportionately likely to have	

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				complicating factors that have influenced their presentation later in pregnancy, including health problems, sexual violence, late detection, a serious change in personal circumstances such as losing their partner, their job, or their house, or foetal anomaly diagnoses. It is unacceptable to consider turning them away and forcing them to continue with their pregnancies as a result of changing the standard of care on the basis of minimal evidence. • Women's experience would be significantly worse – particularly for those women who have work or caring responsibilities or who have to travel longer distances (which is not unreasonable to expect at later gestations). Up to 8000 more women a year may be required to have 3 appointments, two on consecutive days. Other women will have to spend longer in clinic while waiting for osmotic dilators – compared, for instance, to self-administration of mifepristone at home in advance of an appointment. • The draft guideline is recommending a process which is less preferred by women, which will require additional appointments, have a negative impact on treatment and waiting times, and which is not currently used by either of the	

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				independent sector providers which provide the vast majority of abortions during this period. Based on these proposals, we find it difficult to imagine that later surgical services would not have to reduce the number of patients they could treat. The risk of serious disruption to this critical national service as a direct result of this recommendation should not be underestimated. ➢ We recommend, in conjunction with our comment 38 that 1.12.3 is amended to 'offer mifepristone, misoprostol, osmotic dilators, or a combination for cervical priming' to enable clinicians to offer both pharmacological and physical priming as appropriate We recommend amending 1.12.4 to an 'offer' paragraph from 20+0 – 23+6 weeks' gestation	
British Pregnancy Advisory Service (BPAS)	Guideline	19	17	The recommendation to consider general anaesthesia is out of step with RCOG's 2011 guidance on Care for Women Requesting Induced Abortion and WHO's 2015 Safe Abortion guidance – particularly without a gestation restriction. Given additional risks of general anaesthesia, existing evidence and guidance, and recovery time, there should be an additional recommendation that general anaesthesia is not recommended before 14+0 and that the recommended alternative to local anaesthesia in first and early second trimester is sedation rather than GA.	Thank you for your comment. This recommendation is not inconsistent with RCOG's 2011 guidance. The RCOG guidance states that services should be able to provide surgical abortions without resort to general anaesthesia. They do not state that general anaesthesia should not be given. The evidence considered by the WHO guidance is very old and therefore not relevant to current practice due to changes in anaesthesia methods. The committee agreed in the absence of evidence of any method of anaesthesia being superior to any other that

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					women should be offered the choice and the differences between methods explained.
British Pregnancy Advisory Service (BPAS)	Guideline	20	12	This recommendation does not reflect current practice across many providers – where women self-manage at home and are provided with contact details for aftercare and to follow-up with the clinic if they so wish (eg for repeat ultrasound post-treatment). Women do not report needing pro-active follow-up and a very small minority pro-actively contact clinics post-procedure. The evidence provided in Evidence Review O is primarily focused on foetal anomaly terminations or women under the age of 18. None of the evidence considered refers to women over the age of 18 having first trimester terminations for reasons other than foetal anomaly – any conclusions drawn in relation to 1.14.1 are therefore without a clear evidential basis. We would recommend either removing the provision for 'remote assessment' or making this specific sub-section a consider rather than an offer point. (i.e. 'offer the choice of self-assessment, and consider using remote assessment (for example telephone or text messaging), as an alternative to clinic follow-up')	Thank you for your comment. Evidence for self-assessment without remote follow-up was not reviewed as part of this guideline. Therefore, the committee could not recommend this.
British Pregnancy Advisory Service (BPAS)	Guideline	20	18	We would recommend re-ordering these bullet points to be in time order so that problems post-procedure is first, aftercare and follow-up is second, and emotions is third.	Thank you for your comment. The committee discussed this and agreed that routine follow-up/aftercare should appear before complications as this would apply to all women and complications would only be relevant to some women.

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British Pregnancy Advisory Service (BPAS)	Guideline	21	12	The recommendation for intrauterine methods (line 10) to be available on the same day as medical termination of pregnancy is clinically incorrect – something which is recognised on line 23. EMA patients cannot have intrauterine methods fitted on the same day as treatment and this should be made clear. At the same time, commissioners and providers should ensure that IUCDs are available to women accessing EMA – which at the moment is generally not the case owing to a lack of funding for clinic time to fit IUCDs on a return basis for women who have already had their treatment. We recommend that 'or, where necessary, as soon as possible after expulsion of the pregnancy' is included in line 12 after 'same day'	Thank you for your comment. The timing of insertion of IUDs is addressed specifically in recommendation 1.15.4. The committee agreed that including this information in recommendation 1.15.1 may detract from the key point of this recommendation, which is that the full range of methods should be immediately available from the abortion service.
British Pregnancy Advisory Service (BPAS)	Guideline	21	5	It is unclear what is meant by 'emotional support'. Outside post-abortion counselling (which is included later in the point), it is questionable what providers would be in a position to provide and how it would be assessed. It would also indicate an ongoing relationship with a client where most services will not see the vast majority of women after their procedure. We recommend that 'emotional support' is removed from this recommendation and that 1.14.5 focuses on the ability to providers to provide or refer women to counselling services.	Thank you for your comment. Emotional support is referring to any sort of support or discussion about feelings that does not reach a threshold that would be considered as counselling. In the committee's experience, some women do return to services for support and counselling after having an abortion. The recommendations for emotional support and providing or referring to counselling if needed have been separated to aid clarity.
British Pregnancy Advisory Service (BPAS)	Guideline	21	8	BPAS strongly endorses the inclusion of both 'commissioners and providers' in the provision of	Thank you for your comments.

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				contraception to ensure that women are able to access all forms of contraception during the course of treatment.	
British Pregnancy Advisory Service (BPAS)	Economic Model – Service Organisation	Days not weeks sheet		The comparison between days and weeks is incorrect at two levels: • The days are a week out of step with weeks. 28 days of pregnancy is not Week 4 but Week 3 – the figures fail to account for Week 0. Abortion on ground C is currently allowed up to the end of Week 23 (the twenty-fourth week of pregnancy). The days of the week are currently out of step with Department of Health interpretation (and thus the law). The most recent interpretation from the Chief Medical Officer in England is that the twenty-fourth week of pregnancy is exceeded on Day 168 – so week 23 would run from 161-167 (23+0 – 23+6) rather than 162-168 as currently listed.	Thank you for your comment. The model has been corrected in line with your comment by aligning the weeks to days correctly and not distributing individuals for day 168. The conversion from weeks to days was only to allow the model cohort to be uniformly distributed across the week. All costs, type of termination and adverse events and all other outcome measures have been assigned in terms of the weeks reported in the England and Wales Abortion Statistics, and thus no changes have occurred to the outcomes of the model. Consequently, no update has been made to the write-up of the model.
British Pregnancy Advisory Service (BPAS)	Economic Model – Contraception after ToP	Cost injection sheet		The 'Abortion Setting Costs' sheet fails to account for abortion staff costs for consultation or administration that are covered in the implant, IUS, and IUD sheets. The sheet accounts for 20 minutes of GP time for consultation – this should be included as an item in the abortion settings costs. We would estimate nurse consultation in an abortion setting to cost up to £20 for 20 minutes.	Thank you for your comment. The committee made an explicit decision to exclude this cost, to avoid double counting, which is documented in Evidence Report P, Appendix J under heading 'Cost of initial administration of contraception'. The text in this section has been revised to clarify the argument.
Chesterfield Royal Hospital NHS FT	Guideline	General	General	Please consider the following Some instructions about testing for STIs-to offer to all	Thank you for your comment. There was not a question about STI and HIV testing within the scope of this guideline so recommendations could not be made in this area. However, in response to stakeholder comments a cross-reference to NICE

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					PH3 has now been included which covers guidance on interventions to prevent sexually transmitted infections. PH3 is currently being updated.
Chesterfield Royal Hospital NHS FT	Guideline	General	General	Please consider the following Home termination- to complete the procedure in one visit with consultation if patient is certain and trusts should support and should not bring the women back some other day or time for their own convenience.	Thank you for your comment. The whole guideline is dedicated to improving the quality and accessibility of abortion care, and the guideline is clear that services should adopt a women-centred approach. However, how that exactly is done is beyond what the guideline already recommends and may differ between different trusts and the committee were of the opinion that no further clarifications in this respect were required.
Chesterfield Royal Hospital NHS FT	Guideline	General	General	Many thanks for making a detailed and comprehensive guidance	Thank you for your comments.
Chesterfield Royal Hospital NHS FT	Guideline	9	12	We are concerned that this recommendation may need some adjustment that in 2 weeks may be positive creating worries and unnecessary visit. A provision of 3 weeks depending on gestation can be considered.	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The guideline recommends that women are given a low sensitivity or multi-level urine pregnancy test to ensure the correct result after 2 weeks. As complications increase with every week of gestation (see evidence report A), performing a pregnancy test after 2 weeks compared with 3 weeks should improve the safety of another procedure, if required.
Chesterfield Royal Hospital NHS FT	Guideline	12	12	Women can choose to have a depot medroxyprogesterone acetate (DMPA) injection or contraceptive implant fitted when they take the mifepristone tablet. – Very much agreed but to consider adding that contradictory effect of DMPA on Mifepristone is not statistically significant.	Thank you for your comment. This information is included and discussed in more detail in Evidence Report P. The 'Rationale and Impact' section in the guideline also addresses it.

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Christian Action Research and Education (CARE)	Guideline	General	General	We are concerned that in the guideline Final Scope document, it states that *"Care between conception and the request for termination of pregnancy"* will not be covered in the guideline (p. 5, para 3.3). However, several recommendations in this guideline have implications for commissioners, medical practitioners and for women using TOP services both *before* and after a request for termination has been made. Recommendations pertaining to decision-making, the information needs of women prior to going ahead with a termination, pre-abortion counselling and the referral process all partially cover the period between conception and the request for termination. To suggest that these recommendations only pertain to the period after a request has been made also ignores the prevalence of ambivalence amongst women requesting termination of pregnancy. It assumes that the decision to terminate is made once, and finally—as opposed to a process of decision-making that is ongoing (i.e. a woman might change her mind). Our subsequent comments therefore reference how the recommendations in this guideline may affect the decision-making process before the request for termination has been made.	Thank you for your comment. The guidance makes recommendations relating to the request for an abortion but the guideline scope does not cover how the woman makes that decision as this is covered by legislation and professional guidance. The 'this guideline covers' section has been amended to clarify the scope of this guideline and the introductory text has been amended to refer to the Abortion Act and the Department of Health Required Standard Operating Procedures, which provide additional guidance relevant to helping women make a decision. The evidence identified in our review indicates that self-referral improves access and should result in abortions taking place at early gestations, and therefore with less complications. Our evidence review found that women want improved access and better information provision. Recommendation 1.1.8 has been amended to say women should be provided with, or referred to support to make a decision if they request this.
Christian Action Research and Education (CARE)	Guideline	General	General	We are concerned that there is no reference in the guideline to commissioner and providers operating within the law as required in England.	Thank you for your comments. A statement has been added to the beginning of the document to remind healthcare professionals and patients and the public that all abortions must be performed

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				RSOP1 (Required Standard Operating Procedures) states that "*All providers must comply with the Abortion Act 1967 and regulations made under that Act…If an abortion is performed which does not comply with the terms of the Act then an offence will have been committed under the Offences Against the Person Act 1861 and /or the Infant Life (Preservation) Act 1929.*"[4] In making it easier for women to access a termination, it must be clear that the law regarding abortion is complied with at all times. Abortion is regulated by the criminal law. Under the Abortion Act 1967, two registered medical practitioners must be of the opinion, formed in good faith, that the termination of pregnancy complies with one of the Grounds under the Act. Services must not be made more accessible by circumventing this requirement. Services in England must meet the requirements of Regulation 20 of the Care Quality Commission (Registration) Regulations 2009.[5] Any use of medication for a termination must meet the requirements of the Human Medicines Regulations 2012.[6]	within the legal framework set out by the Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990), and its related guidance. A reference to the Department of Health Required Standard Operating Procedures, and other relevant legislation and guidance, has also been included in the introductory text.

4 Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion), Department of Health, May 2014, pages 11-12
5 http://www.legislation.gov.uk/uksi/2009/3112/regulation/20/made
6 http://www.legislation.gov.uk/uksi/2012/1916/contents

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				Use of abortion pills at home must meet the approval requirements set out in England.[7] The committee cannot assume that those using the guideline will be aware of the law and the legal framework surrounding abortion, particularly service users. **We recommend** that the law must be clarified in this guideline in order to ensure that recommendations which will alter service provision meet all the legal requirements set out above.	
Christian Action Research and Education (CARE)	Guideline	General	General	We are concerned that recommendations in this guideline pertaining to navigating the healthcare system, such as making information about TOP services widely available, self-referral, and upfront funding do not accord with the findings in Evidence Review A. The committee state in Evidence Review A that there is "*good evidence*" that demonstrated that the termination process is *"complicated and is not transparent"*, but they also state *"there was no evidence available for strategies to improve navigating the healthcare system."* (p. 37)	Thank you for your comment. The statement "there was no evidence available for strategies to improve navigating the healthcare system" refers specifically to those interventions listed under this heading in the protocol (namely: centralised booking system/single point of contact; public and/or professional awareness campaign; and school-based/youth group education programmes) and the committee did not make recommendations about these methods due to the lack of evidence. The committee discussion section has been amended to explicitly state that there was no evidence for the strategies to improve navigating the healthcare system that were included in the quantitative review protocol. Making information about termination of pregnancy services widely available was recommended based on high quality qualitative

[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/768059/Approval_of_home_use_for_the_second_stage_of_early_medical_abortion.pdf

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					evidence that there is a lack of information available. The committee discussion has been amended to make it clear that this evidence is from the qualitative, not quantitative, review. Self-referral was recommended on the basis of both evidence that more women who self-referred had their abortion within 7 days compared with when women were referred by healthcare professionals and high quality qualitative evidence that decreasing waiting times was an important avenue for improving care. Upfront funding was recommended based on qualitative evidence that raising funds for travel and accommodation can be difficult for women and can cause delays, and the committee's knowledge that women often need to travel at shorter notice for a termination of pregnancy relative to other medical procedures. This is important as complications associated with terminations increase for every week of pregnancy.
Christian Action Research and Education (CARE)	Guideline	General	General	We are concerned that the recommendations pertaining to reducing waiting times and speeding up the referral process are not based on a sufficient quantity and quality of evidence. Evidence Review A states that "*There was good evidence that there are long waiting times and delays when accessing termination of pregnancy services and that decreasing waiting times is an important avenue for improving care.*" (p. 38) However, the evidence base for this in England and Wales appears to be limited. Table 2 of Evidence Review A lists studies included for	Thank you for your comment. The quality of the qualitative evidence (studies described in Table 2) was assessed using the GRADE CERQual methodology, as described in the methods supplement. The GRADE CERQual tables in evidence report A (tables 5 to 12) describe the results of the quality assessment and includes assessment of both the relevance of the evidence to the UK setting and the adequacy of the evidence. These assessments acknowledge where there was a lack of evidence from the UK setting. In these circumstances, the relevance of

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				assessment of factors that hinder accessibility of services. Only 3 of these studies refer to accessibility of services within England and Wales, with evidence varying in quality, and only a small number of participants in two studies (Kumar (21 participants) and Kung (7 participants, none of whom were service users). Furthermore, the Aiken study, which incorporated 519 participants, was described as *'unlikely to be representative of the wider population of women in Britain who want a termination'* (p. 85) Similarly, in Table 4 only 1 study took place in England.	the theme to the UK setting was discussed with the committee and the evidence was downgraded if there were concerns that the evidence was not relevant. However, the committee agreed that the evidence regarding long waiting times and delays was both relevant and adequate, and therefore evidence for this theme was judged as high quality. The studies described in Table 4 relate to the quantitative review, so did not inform the statement regarding evidence for long waiting times and delays; however, the relevance of these studies to the UK setting were also discussed by the committee.
Christian Action Research and Education (CARE)	Guideline	4	4	We are concerned that since this recommendation is relevant for the period when a woman is forming a decision about whether to proceed with an abortion, including after an initial decision is made, information should be provided in line with RSOP12. If information about TOP services is made more widely available, alternatives available to women must also be made widely available in order for women to form an informed decision, being aware of all the options open to them. This is stated in RSOP12: *"Women must be given impartial, accurate and evidence-based information (verbal and written) delivered neutrally"* and this includes "*Alternatives to abortion (for instance adoption and motherhood)."*[8] **We recommend** the wording is changed to:	Thank you for your comment. The guidance makes recommendations relating to the request for an abortion but the guideline scope does not cover how the woman makes that decision as this is covered by legislation and professional guidance. The 'this guideline covers' section has been amended to clarify the scope of this guideline and the introductory text has been amended to refer to the Abortion Act and the Department of Health Required Standard Operating Procedures, which provide additional guidance relevant to helping women make a decision. Our evidence review found that women want improved access and better information provision but it was outside the scope of this guideline to make recommendations about options other than abortion. Recommendation 1.1.8 has

[8] Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion), Department of Health, May 2014, pages 24-25

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				make information about termination of pregnancy services (including how to access them) widely available, as well as information about alternatives such as adoption and motherhood	been amended to say women should be provided with, or referred to support to make a decision if they request this, in response to yours and others' comments.
Christian Action Research and Education (CARE)	Guideline	4	4	We are concerned that, as well as a lack of evidence about what works set out above, it is also unclear whether delays in obtaining terminations are predominantly due to issues in service provision and therefore these recommendations may not have any real impact on the numbers of women accessing medical termination earlier in gestation. One study[9] investigating the experiences of women who had obtained second-trimester abortions in England and Wales suggests that there are numerous factors causing delays. Significantly, the study found that much of the delay occurred prior to women requesting an abortion: half of the 883 women questioned were more than 13 weeks pregnant by the time they requested the abortion. The main reasons identified for delay included *"uncertainty about what to do if they were pregnant, not realising they were pregnant, experiencing bleeding which may have been confused with continuing to have periods, and changes in personal circumstances*." The study's authors also suggest this demonstrates that better education is needed for women to gain the earliest possible	Thank you for your comment. The guideline makes recommendations relating to the request for an abortion but the guideline scope does not cover how the woman makes that decision as this is covered by legislation and professional guidance. The 'this guideline covers' section has been amended to clarify the scope of this guideline and the introductory text has been amended to refer to the Abortion Act and the Department of Health Required Standard Operating Procedures, which provide additional guidance relevant to helping women make a decision. Therefore, the committee could not make recommendations about counselling prior to the request for an abortion and could not address factors that may delay women making the decision to access abortion services. However, recommendation 1.1.8 has been amended to say women should be provided with, or referred to support to make the decision if the request this. The committee did not specify where counselling should be provided pre- or post-abortion as some women may prefer to have this within the abortion service to maintain privacy and confidentiality, but others may want independent counselling which

[9] Ingham et al, 'Reasons for Second Trimester Abortions in England and Wales', *Reproductive Health Matters*, 2008, 16:sup31, 18-29,

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				awareness of pregnancy, rather than merely dealing with the efficiency of services—a factor that does not seem to be addressed in the guidelines. The study's findings are particularly significant to recommendations regarding speeding up service delays. The authors note the following: "*This study has found that, for all age groups and gestations, most reasons for delay are best considered "woman-related'' – i.e. delays in suspecting and confirming the pregnancy and in deciding to have an abortion – rather than ''service-related''. This suggests, for England and Wales at least, limits on the extent to which policy changes directly related to early abortion services can be expected to reduce the proportion of second trimester abortions. This conclusion may come as a surprise; it has been a long-held assumption in the British abortion debate that making early abortion more accessible is the best way to reduce demand for second trimester procedures."*[10] These findings correlate with a 1996 paper which found that most women requesting second trimester abortions *'did not present until a relatively advanced gestational stage. Only 13% of them could have been managed earlier through service improvements.'*[11] Similarly, a 2005 study by Marie Stopes International[12] found that a small minority of	has been suggested by other stakeholders. The committee also agreed that, beyond a certain threshold, it may not be in the best interest of the woman to have counselling within the service as they are unlikely to have as much expertise as specialist services. Therefore the recommendations has been left as 'provide or refer' to give services and women the options of both providing this in house and referring to independent services.

[10] Ibid
[11] George A, Randall S. Late presentation for abortion. *British Journal of Family Planning* 1996;22: 12–15
[12] Marie Stopes International. Late Abortion: A Research Study of Women Undergoing Abortion between 19 and 24 Weeks Gestation. London, MSI, 2005

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				women who had awareness of their pregnancy at an early stage either *"denied this was the case"* or only decided later that the pregnancy was unwanted due to changes in their circumstances. Many of these women found the decision to terminate "*difficult and reported that it took them time to decide to proceed with it."* Some reported delays in accessing services, although the study suggests that "*given that most did not realise they were pregnant until relatively late, the effect was primarily to shift the abortion further into the second trimester."* Ingham et all note that one conclusion from these studies is that "*while accessibility of abortion services plays a part, it is only one part of the explanation for second trimester abortion."*[13] In this context, CARE recommends information about counselling services should be made widely available so that women have the opportunity to consider their options early in their pregnancy. RSOP12 states: *"All women requesting an abortion should be offered the opportunity to discuss their options and choices with, and receive therapeutic support from, a trained pregnancy counsellor and this offer should be repeated at every stage of the care pathway."* [14] The counsellor should be independent of any particular abortion clinic so that there is no conflict of interest. We therefore recommend the following addition:	

[13] Ingham et al, *Op Cit,* 2008

[14] Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion), Department of Health, May 2014, pages 24-25

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				Make information about independent counselling services widely available throughout the care pathway, including during the decision-making process, prior to a termination and after the termination has been carried out.	
Christian Action Research and Education (CARE)	Guideline	4	9	We are concerned that this recommendation is unclear because there is no explanation for what is meant by self-referral. If self-referral means a woman can go to a clinic and have an abortion without medical examination, we have significant concerns about this proposal**.** **Self-referral cannot be an option that circumvents proper medical examination, safeguarding nor the requirements of the law.** This 2010 article refers to an "open referral pathway to accessing NHS abortion services".[15] If a woman can go to a clinic or hospital for examination and assessment against the legal grounds for an abortion, it is not clear how a clinic or NHS hospital will have access to a woman's medical records to ensure there are no medical contraindications. If self-referral under these circumstances is to be promoted, registered medical professionals within the NHS or at a clinic need to ensure they carry out all appropriate medical checks and complete all relevant forms before performing an abortion. They should also ensure that there are no issues of coercion and abuse and ensure that they provide	Thank you for your comment. Recommendation 1.1.2 says women should be allowed to self-refer to services. This recommendation was made in response to evidence that there can be delays getting GP appointments, that physicians can obstruct access to abortions and that women are seen quicker if they self-refer compared to if they are referred by a healthcare professional. However, this recommendation is not prioritising self-referral over a consultation with, and referral from, a GP and this option is still available for women who would prefer this. The committee agree that, if a women chooses to self-refer, it is the responsibility of the abortion service to ensure that there are no medical contraindications and that there are no safeguarding or coercion concerns. This is part of basic clinical care, would apply regardless of the medical procedure in question and the General Medical Council (https://www.gmc-uk.org/ethical-guidance/ethical-hub/adult-safeguarding) provides guidance on this. A statement has been added to document to remind healthcare professionals that all care must

[15] https://www.tandfonline.com/doi/abs/10.3109/01443615.2010.506964?journalCode=ijog20

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				an opportunity "*to make sure women's concerns and fears about abortion are appropriately addressed*". [16] As per the recommendation of RSOP3, a woman's GP should be notified if an abortion takes place.[17] However, we note that there does not seem to be significant evidence for outcomes in practice so it is not clear how this recommendation will make a difference to patients. The committee state in Evidence Review A that "*There was evidence that more women who self-referred had their termination of pregnancy within 7 days of referral compared with women who were referred by a healthcare professional; however, this was based on very low quality evidence and there was no difference in the proportion of women who had their termination of pregnancy within 14 days of referral.*" (p. 38) Our recommendation would be that a woman is referred through her GP. **We recommend** the wording is changed to: **Commissioners and providers should provide opportunities for face-to-face consultations for women to:** • **ensure any concerns about abortion are addressed,** • **check for gestation and medical contraindications;**	be given within the constraints of the Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990). The evidence showed that women have concerns about the privacy and confidentiality of abortion services and reactions and judgements from others; therefore, the committee made recommendations to reflect this. However, the committee agree that sometimes there may be a compelling need to share information if it is in the woman's best interest; this is discussed in evidence report A.

[16] Ingham et al, *Op Cit,* 2008
[17] Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion), Department of Health, May 2014, page 14

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				• **confirm that the abortion falls within the grounds under the Abortion Act 1967;** • **ensure an abortion is medically and legally appropriate; and** • **identify issues of coercion or abuse.** **However, if women wish to self-refer, providers of termination of pregnancy services must ensure the above issues are addressed. They should act as a second line of safeguarding and ensure staff have effective training in identifying signs of abuse.**	
Christian Action Research and Education (CARE)	Guideline	4	11	This recommendation implies that healthcare professionals have no right to conscience. Conscience is protected under section 4 of the Abortion Act 1967, Article 9 of the European Convention on Human Rights, Resolution 1763(2010) of the Parliamentary Assembly of the Council of Europe[18] and the Equality Act 2010. Healthcare professionals should follow the relevant guidance, e.g., the GMC Guidance and General Pharmaceutical Guidance.[19] **We recommend** this is changed to: **Healthcare professionals should follow professional guidance on matters of conscience if they object to providing access to termination of pregnancy services.**	Thank you for your comment. This recommendation is consistent with professional guidance (e.g., the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice) as healthcare professionals have a right to their personal beliefs and to opt out of performing a procedure, but cannot opt out of providing access. Additional information has been added to the rationale to clarify this.
Christian Action Research and Education (CARE)	Guideline	5	1 - 3	There is evidence that reducing waiting times may have negative consequences for some women.	Thank you for your comment. There is evidence (Cameron 2013) that most women (93%) are

[18] http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=17909

[19] http://www.gmc-uk.org/static/documents/content/Personal_beliefs-web.pdf; General Pharmaceutical Council: In practice: Guidance on religion, personal values and beliefs, June 2017, https://www.pharmacyregulation.org/sites/default/files/in_practice-_guidance_on_religion_personal_values_and_beliefs.pdf

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				One study raised this point: *"The only concern related to the greater efficiency associated with establishment of a centralized referral service is that the shortened referral time may lead a small proportion of women to undergo an abortion they may later regret"*[20] We are concerned this recommendation may place undue pressure on women to rush ahead with the termination. Although women need to be informed of the risks of delaying termination, it is important that this is balanced with information regarding the risks of going ahead with terminations—even at this stage where they are still deliberating. This recommendation also seems somewhat at odds with the RSOP guidance which states that if a woman is ambivalent (albeit following counselling) she *'can be given a provisional appointment for admission but must be told that the procedure can be postponed or cancelled and that she remains free to continue with the pregnancy, if she so wishes.'* (RSOP14)[21] **We recommend** this is changed to: **For women who would prefer to wait longer for a termination of pregnancy, explain the implications so they can make an informed decision, but ensure that this places no pressure on women. If women are ambivalent about termination, reassure them that they can be given a provisional appointment for a**	certain of their decision to not continue a pregnancy at the point at which they request an abortion. Therefore, once a women has requested an abortion she should not be faced with unnecessary delays due to the organisation of services. Recommendation 1.1.7 was included to ensure that women can wait longer to have an abortion if they would prefer this for whatever reason, including if she is still considering her options. Recommendation 1.1.8 has also been amended to say women should be provided with, or referred to support to make a decision if they request this. The rationale has been expanded to clarify this. A reference to the Department of Health Required Standard Operating Procedures, and other relevant legislation and guidance, has been included in the introductory text and a note has been added to the beginning of the document to remind healthcare professionals of their duty to ensure they are adhering to all applicable requirements.

[20] https://www.ncbi.nlm.nih.gov/pubmed/1743956
[21] Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion), Department of Health, May 2014, pages 26-27

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				termination, but that they can postpone or cancel at any time and are free to continue with the pregnancy if they wish.	
Christian Action Research and Education (CARE)	Guideline	5	4	This recommendation implies that both counselling and a waiting period are required before an abortion, which is not the case. Furthermore, this recommendation paints counselling in a negative light. There is little evidence-base for this recommendation, other than the effect this has on waiting times in jurisdictions outside of England and Wales. The committee state on page 25, line 19 that '*based on their experience'* policies such as compulsory counselling or waiting periods can '*cause distress'.* This suggests that there might be no good reason to seek counselling in the context of TOP services; and indeed that it can be negative Given that this guideline is also designed for service users, counselling ought to be presented as a positive option for women in order to align with RSOP14 which says "*All women requesting an abortion should be offered the opportunity to discuss their options and choices with, and receive therapeutic support from, a trained pregnancy counsellor and this offer should be repeated at every stage of the care pathway*." [22] The committee ought to note the importance of counselling in aiding women's decision making and allowing women the opportunity to discuss their options, as indicated in several studies. In a study	Thank you for your comment. The rationale has been amended to explain that neither enforced counselling nor time for reflection are a legal requirement. However, recommendation 1.1.7 was included to ensure women can wait longer for an abortion if they would prefer this. Recommendation 1.1.8 has also been amended to say women should be provided with, or referred to support to make a decision if they request this. However, there is evidence from a more recent study (Cameron 2013) that the majority (93%) of women are sure about their decision to proceed with the abortion at the point of making the request. The wording of the discussion in evidence report O has been amended to provide additional information about why the committee agreed it was not appropriate to offer everyone counselling as this may set the expectation that women will feel bad and need counselling, which could make them feel worse. The committee did not think it was appropriate to specify where counselling should be provided as some women may prefer to have this within the abortion service to maintain privacy and confidentiality, but others may want independent counselling which has been suggested by other stakeholders.

[22] Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion), Department of Health, May 2014, pages 26-27

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				by Ingham et al (2005), the most common factor causing women to delay their abortion to the second trimester was ambivalence: 41% of women in the study were unsure about having an abortion and had '*great difficulty'* in making the decision. Notably, delays caused by the woman's indecision, were also compounded by responses of partners.[23] In a study on ambivalence during early pregnancy[24], the authors concluded that *'The conflict of wanting or not wanting to have a child must be solved in the decision-making process that precedes the choice of whether to interrupt a pregnancy or carry it to full term. The time limit for this decision making process is reduced by the medical abortion methods now available.'* The study notes that *'Hasty early abortions as well as delayed abortions create problems and should be avoided.'* It does not appear the committee has considered the implications of the former, as the guidelines only focus on speeding up the abortion process. Another study[25] in 1995 found that 30% of subjects were ambivalent about the decision to terminate when the abortion was due. Of the women who were ambivalent, they had less supportive partners than the non-ambivalent group and in 16% of these cases the partner made the decision for them. The study notes that '*36% of the ambivalent women felt*	

[23] Ingham et al, *Op Cit*
[24] Holmgren et al, 'Ambivalence during Early Pregnancy among Expectant Mothers', Gynecol Obstet Invest 1993;36:15–20
[25] Husfeldt et al, 'Ambivalence among women applying for abortion', Acta Obstet Gynecol Scand. 1995 Nov;74(10):813-7.

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				they had not received adequate information from their physician about their legal rights should they choose to continue with the pregnancy, and 47% indicated they would have changed their decision given different personal circumstances, including partner support or improved socioeconomic conditions.' The authors conclude that '*Counselling of abortion seekers is essential to reduce the element of doubt in the decision making process and mitigate post-abortion depression and regret*.' This indicates that care should be taken by medical professionals in how women are taken through the abortion pathway—women should not be rushed into making a decision regarding termination of pregnancy and should have the opportunity to discuss their concerns with a counsellor. Indeed the committee notes in Evidence Review O that "*There was evidence that women may need support following termination of pregnancy for a number of reasons, including: dealing with isolation, negative feelings, milestones and the future, and to receive answers to specific questions and have someone validate their feelings."*[26] This should alert the committee to the importance of ensuring abortion counselling is offered to women. However, the committee '*did not think it was appropriate to offer [post abortion] counselling as standard, despite this arising as a theme in the qualitative evidence, as some women do not feel*	

[26] Evidence Review O, p. 14

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				they need support and may actually feel relieved after a termination of pregnancy and want to move on."[27] It is questionable why the committee is ignoring this theme in the qualitative evidence, despite included studies pointing out that *"On some occasions it may be easier for women to be part of a system that guides them through managing their difficulties without them having to be asked if they want to be a part of it."*[28] Given this evidence, recommendations regarding counselling clearly affect women's experiences in the decision-making process and this recommendation therefore has implications for women both prior to and after requesting a termination. **We recommend** this is changed to: **Women should be offered the option of independent counselling services at each stage of the care pathway.**	
Christian Action Research and Education (CARE)	Guideline	5	7	We are concerned that this recommendation may not uphold the law. In Evidence Review A, it states: *"The committee agreed that appropriate methods of remote assessment may also include online services such as Women on Web and may expand with future advances in technology. The committee acknowledged that current regulations in England would prevent some aspects of the care pathway being delivered by telemedicine but the*	Thank you for your comment. The reference to women on web has been removed from the discussion in evidence report A. All healthcare professionals providing abortion services must work within the constraints of the law, including ensuring women satisfy one of the grounds of the Abortion Act. A note has been added to the beginning of the document to remind healthcare professionals of their duty to comply with the law. A reference to the Department of Health Required

[27] Evidence Review O, p. 15
[28] Evidence Review O, p. 33

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				circumstances in which services could be delivered remotely may expand following the announcement to legalise home use of misoprostol in England by the end of 2018." (p. 40) The 2014 DH Guidance in relation to requirements of the Abortion Act 1967 says "*Whilst there is no statutory requirement for either doctor to have seen and/or examined the woman, it is the Department's interpretation of the law that both doctors should ensure that they have considered sufficient information specific to the woman seeking a termination to be able to assess whether the woman satisfies one of the lawful grounds under the Abortion Act*." (para 12) We are concerned that the committee is advocating Women on Web since it advertises itself as available where "The doctor can only help you if: you live in a country where access to safe abortion is restricted; you are less than 10 weeks pregnant; you have no severe illnesses" i.e. it is operating outside of the law on abortion and potentially outside the Human Medicines Regulations 2012. **Any consultation prior to a termination must ensure that it meets the legal requirements**.	Standard Operating Procedures, and other relevant legislation and guidance, has also been included in the introductory text.
Christian Action Research and Education (CARE)	Guideline	5	7	We are concerned that this recommendation may not be in the best interests of patients nor maintain patient confidentially. Clearly, the use of video calls within the NHS in increasing and is to be welcomed. However, a doctor may need to examine a patient seeking an abortion both to confirm gestation and any medical contraindications. It therefore seems unlikely that	Thank you for your comment. It is part of basic clinical practice for healthcare professionals to be alert for signs of physical or emotional abuse or coercion, and therefore not necessary to make a specific recommendation in this guideline. The committee recommended phone or video call assessments as they could help women that are under pressure from families or abusive partners to access services remotely that they would

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				video calls nor the phone will be sufficient to ensure that a woman is suitably advised and the doctor can meet their professional and legal obligations. Furthermore, it also does not appear that such services significantly improve patient satisfaction. Evidence Review A states: *"Non-RCT evidence showed there was no clinically important difference between the rate of women rating overall satisfaction as 'very satisfied' (1 observational study, n=431; RR=1.07 [95% CI 1.01, 1.13]; very low quality)in the 'community or hospital services' group and the 'telemedicine' group."*[29] We have considerable concerns about recommendations regarding the use of telemedicine in abortion services, particularly in terms of safeguarding. For example, controlling circumstances including *"partner violence and partner/family control"* was listed as a factor in Aiken (2018)[30] inducing 18% of respondents to resort to telemedicine through Women on Web. This demonstrates the significance of the two-doctor requirement and the oversight of medical practitioners in the abortion process, as a safeguarding matter. This is significant, given the committee felt that their recommendations to move towards telemedicine services has "*the potential to reduce inequalities associated with certain groups who find it particularly difficult to*	otherwise not be able to do, as well as other reasons for not being able to access services such as location. When the lack of difference in patient satisfaction between community or hospital services and telemedicine was considered in combination with qualitative evidence that showed that making travel arrangements can cause delays to accessing abortion services and that community prescribing for medical abortion and telemedicine either has, or would, improve access to abortion services, increase flexibility and facilitate a more woman-centred approach to care, the committee agreed that remote assessments should be available and may improve access. This is explained in the committee discussion in evidence report A, which also acknowledges that these methods may not be suitable for all women and more traditional hospital-based and face-to-face services should also be available.

[29] Evidence Review A, p. 30
[30] https://www.contraceptionjournal.org/article/S0010-7824(17)30435-3/fulltext

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				travel to termination of pregnancy services." If such groups are potentially vulnerable to scenarios of coercive control or domestic abuse, this demonstrates an enhanced need for safeguarding protection through face-to-face contact with a medical professional. Increased access to telemedicine does not reduce inequalities for women in domestic abuse scenarios as it does not help them exit situations of abuse. It undermines the support services in place through visiting a GP or TOP service provider where professionals are trained to spot signs of abuse. For example, this study states the following: *"Attendance at health care facilities such as abortion or antenatal clinics brings women into contact with services and potential interventions. Professionals may be able to ask about DV and offer information and referral to support agencies."*[31] We are also concerned that there could be confidentiality issues arising from technology. In the light of the above comments, **we recommend** that this guidance is removed. Should the Committee continue to keep this section of the guideline, we recommend the following alternative text: **Consider providing termination of pregnancy consultations by phone or video call, only**	

[31] https://srh.bmj.com/content/41/2/128

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				where this upholds the law, maintains confidentiality, is medically appropriate and ensures safeguarding.	
Christian Action Research and Education (CARE)	Guideline	5	9	We are concerned that this recommendation is unclear because there is no explanation of what 'in the community' means and **we recommend** this needs to be clarified and how this relates to the requirement for abortions to be performed in a place approved by the Secretary of State. It is also questionable why this recommendation is being made, when there is no clear evidence that providing services in the community entails any significant benefit in reducing waiting times: *"Non-RCT evidence showed there was no clinically important difference between the time between referral and assessment in the 'community services' group and the 'hospital services' group"*[32]	Thank you for your comment. Community services in the context of abortion refers to abortion clinics and services that are provided outside the hospital setting and are approved by the Secretary of State for Health and Social Care. All healthcare professionals providing abortion services must work within the constraints of the law and a note has been added to the beginning of the document to remind healthcare professionals of their duty to do so. There was no evidence from the quantitative review that community services reduced waiting times. However, there was some evidence that patient satisfaction may be higher with community services compared with hospital services and there was good evidence from the qualitative review that travel arrangements can cause delays to accessing abortion services and that community prescribing for either has, or would, improve access to abortion services, increase flexibility and facilitate a more woman-centred approach to care. So when the qualitative and quantitative evidence were considered together, the committee agreed that community services may improve access. This is explained in the discussion in evidence report A.
Christian Action Research and Education (CARE)	Guideline	5	13	We are concerned that this recommendation may imply that two doctors no longer are required to	Thank you for your comment. Any treatment given by any healthcare professional must be within the

[32] Evidence Review A, p. 30

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				agree to an abortion under the law. Any recommendations on increasing the role of nurses and midwives must meet the requirements of the law and allow them to exercise their right to refuse involvement in any abortion procedures on the grounds of conscience. **We recommend** the following alternative: **Termination of pregnancy providers should maximise the role of nurses and midwives in providing care only after two registered medical practitioners have certified that they are of the opinion formed in good faith that the abortion request meets the legal requirements. Nurses and midwives must be able to exercise their right to conscientiously object to involvement in any procedures related to abortion.**	constraints of the law. A reference to the Abortion Act and the Department of Health Required Standard Operating Procedures, and other relevant legislation and guidance, has been included in the introductory text and a note has been added to remind healthcare professionals of their duty to work within the constraints of the law and ensure they are adhering to all applicable requirements. The management of conscientious objection is the right of all healthcare professionals and is covered by legislation and relevant guidance (e.g. the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice). Therefore, it is not necessary to make additional recommendations relating to it in this guideline.
Christian Action Research and Education (CARE)	Guideline	5	21	We are concerned that this recommendation sets up issues of conscience against the speed of procedures, and ignores the conscience clause in the 1967 Act and the GMC guidance (GMC Guidance *Personal Beliefs and Medical Practice,* in effect from April 2013.[33] We are also concerned that taking an 'opt-out' rather than an 'opt-in' approach will potentially create barriers for trainees with a conscientious objection. This approach may create stigma for these trainees and distinguish them from others,	Thank you for your comment. There was good evidence that the proportion of clinicians providing, or intending to provide, abortions was higher when an opt-out approach was used compared with an opt-in approach. Not enough new trainees are acquiring skills needed to perform abortion and, therefore, abortion services will not be sustainable in the future unless this changes. Therefore, the committee agreed an opt-out approach should be recommended. Recommendation 1.1.13 includes a clause about opting out due to conscientious objection and is,

[33] http://www.gmc-uk.org/static/documents/content/Personal_beliefs-web.pdf

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				creating pressure for them to train in an area to which they conscientiously object. We are also concerned it will create barriers for career progression if training in TOP services becomes a 'default' requirement, rather than an additional option that may be selected by trainees. The opt-out approach is also not in keeping with the professional inclinations of most medical students. According to Gleeson et al (2008), medical students in the UK '*would not perform'* terminations in the majority of scenarios. The study found that 37% would perform if '*child unwanted'*; 38% if the fetus was at risk of a serious disability and 46% if the fetus was guaranteed to have a serious disability.[34] **We recommend** the following alternative: **Training in termination of pregnancy can be offered to all trainees, who can choose to opt-in without any pressure to do so.**	therefore, consistent with guidance from the General Medical Council (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice).
Christian Action Research and Education (CARE)	Guideline	6	1	We are concerned that this recommendation could be interpreted as requiring trainees to have training in abortions. For the same reasons as set out above, **we recommend the** following alternative text: **If a trainee's placement service does not provide termination of pregnancy, the trainee should gain experience with whoever is**	Thank you for your comment. The previous recommendation states that trainees can opt-out of abortion training under the grounds of conscientious objection. Therefore, recommendation 1.1.14 follows on from this to explain that if they have not opted out but their placement does not provide abortions then they should be given the opportunity to gain this experience in an alternative service.

[34] https://www.ncbi.nlm.nih.gov/pubmed/18974410

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				providing this service (either in the NHS or in the independent sector) if they so wish.	
Christian Action Research and Education (CARE)	Guideline	6	15	We are concerned that this recommendation could be interpreted as implying that healthcare professionals who have a conscientious objection to abortion have a '*negative and judgemental attitude'*. We therefore suggest that this is removed. Women may experience stigma when undergoing termination of pregnancy for a number of reasons. For example, women may face negative reaction from their family or friends in regard to seeking termination of pregnancy; women may also be experiencing anxiety due to their own ambivalence about the termination; or they may be distressed due to domestic abuse or coercion. **We therefore recommend** the wording be changed as follows: **When caring for women who are having a termination of pregnancy, be aware of:** • **Anxiety they may be experiencing due to perceived negative reactions from others** • **Anxiety due to ambivalence about the procedure, and whether they might require counselling to aid them in the decision-making process** • **Anxiety or distress from potential coercion or domestic abuse** **The impact that verbal and non-verbal communication may have on them.**	Thank you for your comment. The language used in the recommendation is consistent with the qualitative evidence reviewed. This is not implying that having a conscientious objection itself is a negative or judgemental attitude. However, it is important how this objection is communicated to patients and the General Medical Council has specific guidance about not implying or expressing disapproval of the patient's lifestyle, choices or beliefs (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice). There is evidence (Cameron 2013) that the majority of women are sure of their decision to proceed at the point of requesting a termination. However, help making a decision and requiring extra time to make a decision are covered by recommendations 1.1.7 and 1.1.8.
Christian Action Research and Education (CARE)	Guideline	6	21	We are concerned that this recommendation may imply that record keeping is unnecessary.	Thank you for your comment. This recommendation refers to sharing information, not

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				Record keeping is essential for the medical record of the woman (RSOP3 recommends that the woman's GP is notified[35]) and the notification requirements within the Abortion Act 1967 and associated regulations and in England Regulation 20 of the Care Quality Commission (Registration) Regulations 2009.[36] **We therefore recommend** the wording be changed as follows: **Services should be sensitive to the concerns women have about their privacy and confidentiality, including their concerns that information about the termination of pregnancy will be shared with healthcare professionals not directly involved in their care, while maintaining all record keeping requirements.**	record keeping. The committee agreed it was not necessary to specify that record keeping needs to be maintained as this is a legal requirement. A statement has been added to the beginning of the document to remind healthcare professionals and patients and the public that all abortions must be performed within the legal framework set out by the Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990), and its related guidance.
Christian Action Research and Education (CARE)	Guideline	7		**Table 1** We are concerned about the accuracy of the statement "*Depending on the circumstances, gestational age and the woman's preference, the medical procedure may take place at home or in a clinic or hospital".* It is important to clarify that only misoprostol is permitted to be taken at home and women still need to obtain both pills from a registered place. We **recommend** the following alternative:	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists. The PDA will cover expulsion at home and will clearly reflect the recommendations in the guideline. The evidence review that these recommendations are based on addresses the question of the gestational age at which it is safe to pass a

[35] Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion), Department of Health, May 2014, page 14
[36] http://www.legislation.gov.uk/uksi/2009/3112/regulation/20/made

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				Depending on the circumstances, gestational age and the woman's preference, the medical procedure may take place in a clinic or hospital, and following administration of mifepristone in a clinic, a woman may then take misoprostol at home (depending upon gestation) or at a clinic/hospital.	pregnancy at home. The evidence reviewed did not address the gestational age at which misoprostol can be taken at home, as this is specified in the 2018 Secretary of State approval order. However, the recommendations have been amended to clarify that women up to 9+6 weeks gestation can take the misoprostol at home (or in clinic/hospital) and expel the pregnancy at home but women at 10+0 will have to take the misoprostol in clinic before expelling the pregnancy at home. Where mifepristone is taken was not included in the recommendations as it is a legal requirement that this is taken at an approved place. A statement has been added to the beginning of the document to remind clinicians of their duty to adhere to all relevant legislation and requirements.
Christian Action Research and Education (CARE)	Guideline	7	2	We are concerned that this recommendation does not provide an accurate position of either the risks for women or the legal obligation on providers to ensure that women are made aware of all the risks. Following *Montgomery v Lanarkshire Health Board* [2015] UKSC 11,[37] women must be made fully aware of all material risks involved in a procedure, however small, and alternatives should be discussed with the patient before the procedure. This recommendation does not comply with this ruling.	Thank you for your comment. The committee agree that it is necessary to fully inform women of risk associated with having an abortion but have not made exhaustive recommendations about this as it is part of good clinical practice. The introductory text has been amended to remind healthcare professionals to provide information and obtain informed consent in line with General Medical Council (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent) guidance and the 2016 Montgomery ruling and to

[37] https://www.supremecourt.uk/cases/docs/uksc-2013-0136-judgment.pdf

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				RSOP12 states that *"Women must be given impartial, accurate and evidence-based information (verbal and written) delivered neutrally covering* • *Alternatives to abortion (for instance adoption and motherhood)* • *Abortion methods appropriate to gestation* • *The range of emotional responses that may be experienced during and following an abortion* • *What to expect during and after the abortion (to include potential side effects, complications and any clinical implications)"*[38] There is nothing in this guideline which recommends information covering adoption and motherhood. We recommend that this is included to comply with RSOP12. It appears that this recommendation is made on the grounds of the committee's concerns about '*misinformation'* from *'anti-termination groups'* suggesting that there is increased risk of '*infertility, cancer, mental illness or life-threatening complications arising from terminations despite the best available evidence and systematic reviews offering reassurance that there is no evidence of increased risk of significant long term effects in women who choose a termination compared to those who continue with pregnancy.'*[39]	include a reference to the Department of Health Required Standard Operating Procedures The guideline is for people who have requested an abortion and covers safe and effective abortion care. The alternative options to abortion are outside the scope of this guideline. The statement that there is no evidence of increased risk of significant long term effects in women who choose a termination compared to those who continue with pregnancy does not contradict the evidence presented in Table 1 as these are short-term complications, as opposed to long-term outcomes. The evidence for long-term health risks was not formally reviewed as part of this guideline. The language in recommendation 1.2.1 has been amended to just mention infertility, breast cancer and mental health problems, not all long-term health risks. These specific complications were selected because they are covered in the RCOG guidelines, the committee agreed these are those that most commonly cause distress to women and for which the best available evidence shows that there is no increased risk (see evidence report B). The committee acknowledge that there may be some evidence (although this was not reviewed as part of this guideline) of an association between abortion and risk of subsequent pre-term birth but agreed that the evidence for this is less definitive

[38] Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion), Department of Health, May 2014, pages 24-25
[39] Evidence Review B, p. 19

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				This statement contradicts the evidence presented in Table 1 which indicates that women in a minority of cases can experience severe bleeding, infection, sepsis, uterine perforation and injury to the cervix. There is solid evidence of a link between abortion and subsequent preterm birth. This risk is small but certainly real, and is acknowledged by the RCOG.[40] In 2013, a review of induced abortion and early preterm birth found "*a significant increase in the risk of preterm delivery in women with a history of previous induced abortion*." Women who had one prior induced abortion were 45% more likely to have premature births by 32 weeks, 71% more likely to have premature births by 28 weeks, and more than twice as likely (117%) to have premature births by 26 weeks.[41] A further study conducted in Finland in 2013 found a 28% higher risk of an extremely preterm birth.[42] Women must be made aware of this risk. These complications can cause long-term health problems, which is stated explicitly on the NHS website: it states that there *'is a very small risk to your fertility and future pregnancies if you develop a womb infection that isn't treated properly'* and '*having several abortions is associated with a*	than for the risks discussed above and so did not make recommendations. Whilst the NHS does recognise risk of PID, it also makes the statement that 'Having an abortion won't affect your chances of becoming pregnant and having normal pregnancies in the future' which is supported by recommendations from the RCOG that women can be reassured that there are no proven associations between abortion and infertility. It is the committees' experience that most women, if they know what to look for, will present with signs of infection and get treatment before PID develops and recommendations 1.2.9 and 1.14.3 cover giving women advice about potential complications. No information was available on the relative risks of infection or infertility after abortion when compared to after birth as this was not included in the scope of the guideline, but the committee were aware that infection post childbirth is common, and sepsis is recognised as an important cause of maternal mortality. In the absence of evidence that abortion was more likely to cause infertility, and given that this is a common source of misinformation that creates anxiety in women as noted by other stakeholder responses,

40 'The Care of Women Requesting Induced Abortion: Evidence-based Clinical Guideline Number 7', Royal College of Obstetricians and Gynaecologists, November 2011, p. 44 https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf

41 Hardy G, Benjamin A, Abenhaim H. 'Effect of induced abortions on early preterm births and adverse perinatal outcomes'. J *Obstet Gynaecol* Can 2013;35(2):138-143 https://www.ncbi.nlm.nih.gov/pubmed/23470063

42 Räisänen S, Gissler M, Saari J, Kramer M, Heinonen S. 'Contribution of risk factors to extremely, very and moderately preterm births — register-based analysis of 1,390,742 singleton births'. *PLOS One.* 2013;8(4):e60660 https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0060660

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				slightly increased risk of giving birth prematurely, before the 37th week of pregnancy in future pregnancies'.[43] Furthermore, women should be made aware of risks and potential long-term complications arising from termination, *regardless* of how this compares with continuation of pregnancy. In Evidence Review A, the committee also state they are *"aware of evidence that mortality from termination of pregnancy, whilst remaining very low in absolute terms, increases for every additional week of gestation (Bartlett 2004)".* This again appears to contradict this recommendation. This recommendation also does not take account of evidence which suggests long term mental health effects of abortion. For example, the Academy of Royal Medical Colleges in 2011, following a comprehensive review of the evidence, found that women who had a history of mental health difficulties before an unwanted pregnancy were at greater risk of mental health problems following an abortion.[44] In 2013, Fergusson et al et al re-examined the results of this review and additional evidence in this area. They came to the following conclusion: *"there is no available evidence to suggest that abortion has therapeutic effects in reducing the mental health risks of*	the committee agreed that there was no rationale to change from the guidance from the RCOG and that women should be offered reassurance. The committee were aware that the Academy of Medical Royal Colleges guidance showed that following an unwanted pregnancy, there was not an increased risk of having mental health problems in women who had an abortion compared with those who have birth. The Ferguson review cited did not control for pre-existing mental health problems, which are more likely to occur again irrespective of whether a woman has an abortion. Further, the Ferguson review acknowledges that comparing women with an unwanted pregnancy that had an abortion with women with an unwanted pregnancy that decided to continue to term may not be the appropriate comparison. They said a more appropriate comparison may be to compare against women with an unwanted pregnancy who were refused an abortion. They were only aware of one study that did this (Gilchrist 1995), but this study showed a higher rate of psychotic illness in women refused an abortion. Therefore, the committee concluded that there was no robust evidence of a link between abortion and mental health problems.

[43] https://www.nhs.uk/conditions/abortion/risks/

[44] Induced Abortion and Mental Health: A systematic review of the evidence' — full report and consultation table with responses, Academy of Medical Royal Colleges (AoMRC), December 2011, pp.8-10. https://www.aomrc.org.uk/wp-content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf

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				unwanted or unintended pregnancy. There is suggestive evidence that abortion may be associated with small to moderate increases in risks of some mental health problems."[45] Two other longitudinal studies in recent times have come to similar conclusions.[46] In order for women to have informed consent, it is essential they are made aware of this potential risk. The committee also discuss in Evidence Review O that *"difficulties experienced by some women may require more intensive psychological therapy."*[47] If a woman requires intensive psychological therapy following an abortion, it cannot be said that termination does not increase their risk of subsequent mental health issues. The committee state in the Final Scope document that *"Specific consideration will be given to women with complex pre-existing medical conditions."* (page 4, para 3.1) This ought to include pre-existing mental health conditions which may be exacerbated following termination. **We therefore recommend** the following change: • **Inform women neutrally of the potential risks and complications that may result**	

[45] Fergusson D, Horwood L & Boden J. 'Does abortion reduce the mental health risks of unwanted or unintended pregnancy? A re-appraisal of the evidence' *Aust NZ J Psychiatry* 2013; 47:1204-1205 https://www.ncbi.nlm.nih.gov/pubmed/23553240

[46] See Pedersen W. 'Abortion and depression: A population-based longitudinal study of young women'. *Scandinavian Journal of Public Health* 2008; 36(4):424-8. *https://www.ncbi.nlm.nih.gov/pubmed/18539697* and Fergusson D, Horwood L & Boden J. 'Reactions to abortion and subsequent mental health'. *British Journal of Psychiatry* 2009; 195(5):420-6 *https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/reactions-to-abortion-and-subsequent-mental-health/667F92342F6A90F4FB3F8235187F7DBB* Fergusson, D, Horwood, L & Boden J. 'Abortion and mental health disorders: Evidence from a 30-year longitudinal study'. *British Journal of Psychiatry* 2008; 193:444-51 https://www.ncbi.nlm.nih.gov/pubmed/19043144

[47] Evidence Review O, p. 15

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				from termination of pregnancy, ensuring that they have informed consent. This includes a small risk of pre-term birth in future pregnancies, and a small to moderate risk of increased mental health difficulties following a termination. **Ensure that women with pre-existing mental health difficulties are aware that a termination may exacerbate their condition. This is particularly important for patients who have a history of suicidality.**	
Christian Action Research and Education (CARE)	Guideline	7	10 - 12	We are concerned that the statement "Medical and surgical termination of pregnancy are both highly effective and safe" is incorrect. There is plenty of evidence outlining the increased risks in medical abortions, as opposed to surgical abortions. For example, there is a greater risk of bleeding and haemorrhage following a medical abortion, as acknowledged by the RCOG.[48] In the United States, in the Food and Drug Administration's clinical trials of the drug mifepristone, 90% of women reported that bleeding was much more severe following a medical abortion than during a heavy menstrual period.[49] The largest and most accurate study of medical abortions by Niinimaki et al, a 2009 study of 42,600 Finnish women who had an abortion, found that these women had four times as many serious	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA does not include the wording you refer to.

[48] The Care of Women Requesting Induced Abortion: Evidence-based Clinical Guideline Number 7', Royal College of Obstetricians and Gynaecologists, November 2011, p. 34
[49] https://www.accessdata.fda.gov/drugsatfda_docs/label/2000/20687lbl.htm

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				complications following medical abortions than surgical abortions: 20% compared to 5.6%. Haemorrhage rates were 15.6% following medical abortions, compared to 2.1% after surgical terminations.[50] Another study by Niinimaki et al in 2011 found that, of the 24,000 women surveyed who had undergone medical, rather than surgical abortions, 15.4% were later diagnosed with bleeding, 10.2% an incomplete abortion and 13% had to proceed with a vacuum curettage.[51] Studies by Mulligan and Messenger[52], Winikoff et al[53] and Raymond et al[54] show similar differences, with the rate of necessary surgery after an early medical abortion ranging from 3.5% to 7.9%, and up to 33% for later abortions. Therefore around one out of every 20 women obtaining an early medical abortion will need surgery for haemorrhage or to remove foetal remains left inside the uterus.	

50 Niinimaki et al, 'Immediate complications after medical compared with surgical termination of pregnancy', *Obstetrics & Gynecology*, 2009 Oct;114(4):795-804 https://www.ncbi.nlm.nih.gov/pubmed/19888037

51 Niinimaki, Gissler et al, 2011. 'Comparison of rates of adverse events in adolescent and adult women undergoing medical abortion: population register based study', *BMJ (Clinical research ed*), 2011; 342 https://www.bmj.com/content/342/bmj.d2111

52 Mulligan, Messenger, 'Mifepristone in South Australia—The first 1343 tablets.' *Australian Family Physician* Vol. 40, No. 5, May 2011: 342-345 https://www.racgp.org.au/download/documents/AFP/2011/May/201105mulligan.pdf

53 Winikoff et al, 'Two distinct oral routes of misoprostol in mifepristone medical abortion: a randomized controlled trial', *Obstetrics & Gynecology,* 2008 Dec; 112(6): 1303-10 https://www.ncbi.nlm.nih.gov/pubmed/19037040

54 Raymond et al, 'First-trimester medical abortion with mifepristone 200 mg and misoprostol: a systematic review', *Contraception*, 2013 Jan: 87 (1) 26-37. https://www.ncbi.nlm.nih.gov/pubmed/22898359

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				Hospitalisation rates for early medical abortions were 5.7%, according to the 2011 Australian review of 7,000 abortions by Mulligan and Messenger, compared to just 0.4% for early surgical abortions. Following mid trimester medical abortions, this study found that *'emergency department presentation and subsequent admission were frequent.'*[55] Complications following a medical abortion are also only reported "*up to the time of discharge from the place of termination"*[56] and therefore any complications after leaving a clinic do not appear in the annual statistics for abortions in England and Wales published by the Department of Health. There is therefore unclear data on the number of complications following medical abortions. We **recommend** that lines 10-12 be replaced with the following: **Providers should ensure women are aware of the risks and complications resulting from medical termination, and ensure they are fully informed of the advantages and disadvantages of both medical and surgical procedures.**	

55 Mulligan, Messenger, 'Mifepristone in South Australia—The first 1343 tablets.' *Australian Family Physician* Vol. 40, No. 5, May 2011, p. 344 https://www.racgp.org.au/download/documents/AFP/2011/May/201105mulligan.pdf

56 Written PQ, 12 September 2017, HC 10119; Abortion Statistics, England and Wales: 2016, Table 8 https://static.rasset.ie/documents/news/abortion-stats-2016-commentary-with-tables.pdf

Consultation on draft guideline - Stakeholder comments table
12/04/19 to 31/05/19

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Christian Action Research and Education (CARE)	Guideline	7 - 11		**Table 1** We are concerned that there are contradictory statements between Table 1 and other text in the document. For instance: • Table 1 says there is no need for routine follow-up but section 1.14 sets out what is required for follow-up (page 20, line 8 to page 21, line 6). • Page 20, line 21 refers to "a range of emotions after the termination", but this is not mentioned as a potential concern for women in Table 1. • Page 36, lines 27-29, states that "*There was a higher clinically important rate of incomplete termination needing additional surgical intervention for women who had medical termination*" but this information is not clear from Table 1. **We recommend** that the information in Table 1 should be consistent with other information in the Guideline.	Thank you for your comment. The information regarding follow-up is not contradictory as recommendations 1.14.1 and 1.14.2 only apply to medical termination before 10+1 weeks and the table says no routine follow-up is required for surgical termination of pregnancy or medical termination after 10+0 weeks. The additional recommendations under section 1.14, including referring to experiencing a range of emotions, relate to support, rather than follow-up and are not included in the table as they do not differ based on the type of termination (medical or surgical). Table 1 includes the number of women per 1000 that required additional surgical intervention (72-130 for medical termination of pregnancy and 28-36 for surgical termination of pregnancy, depending on gestational age), which is consistent with the statement of higher rates of incomplete termination for women who had medical termination referred to on page 36. However, Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline.
Christian Action Research and Education (CARE)	Guideline	8		**Table 1** It is not clear what upper gestation limit is being recommended for medical abortions. **We recommend** that it should be made clear in the Table that unless there is evidence of serious foetal abnormality or the life of the mother is at risk, it is still illegal to terminate a pregnancy beyond 24 weeks.	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA does not address abortions beyond 24 weeks.

Consultation on draft guideline - Stakeholder comments table
12/04/19 to 31/05/19

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Christian Action Research and Education (CARE)	Guideline	8 - 9		**Table 1** The use of the word 'pregnancy' does not accord with the committee's descriptions in Evidence Review B of the 'fetus' (p. 12, 19). **We recommend the word fetus is used consistently throughout the guideline.**	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The guideline refers to various gestations in the recommendations, and it would not be clinically accurate to refer to the pregnancy at some of these points as a fetus. Therefore, the decision was taken by the committee to use the term 'pregnancy' throughout the recommendations for accuracy and consistency. The language in evidence report B has been amended to be consistent with the recommendations.
Christian Action Research and Education (CARE)	Guideline	11	7	This recommendation should be amended to be in line with the requirements of RSOP12 which says, "Information should be available in a variety of languages and formats (e.g. braille, audio-visual) to maximise accessibility. Women should be given the opportunity to take the information away with them if they so wish." [57] **We recommend** that additional words should be included after the first **"information"** so that it says, ***"including different languages and accessible options."***	Thank you for your comment. Detail about the format and language of information was not included in the recommendations as this is covered in the NICE guideline on patient experience in adult NHS services that is referred to in recommendation 1.2.5. This includes oral and written information, different languages and accessible options such as braille, pictures and large print.
Christian Action Research and Education (CARE)	Guideline	12	7	We are concerned that the wording in this recommendation should be accurate. Practitioners should have guidance as to what language they should use. The word 'pregnancy' is vague and may create false expectations for the woman. Use of the word 'pregnancy' also contradicts Evidence Review B	Thank you for your comment. The guideline refers to various gestations in the recommendations, and it would not be clinically accurate to refer to the pregnancy at some of these points as a fetus. Therefore, the decision was taken by the committee to use the term 'pregnancy' throughout the recommendations for accuracy and

[57] Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion), Department of Health, May 2014, pages 24-25

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				which uses the term 'the fetus'. This is a shift in language which sets different expectations. The importance of clear and accurate language in describing the fetus was highlighted in several studies looking at women's experiences of passing a fetus at home, included in Evidence Review B. Participants described how *"women were not given enough information to prepare them for the abortion, which is a responsibility of the caregivers: "I was not prepared for the "little human being" about 12 in."*[58] Another study found women reacted similarly to a lack of information: "*Women stated that all patients should be informed at the clinic about what the products expelled would look like. Two women pointed out that they had been unprepared to see the amniotic sac and the embryo: '. . . saw something that looked like a small amniotic sac . . . hard . . . was not prepared for it . . .' and '. . . I put a paper in the toilet so I would see that I had aborted . . . was totally unprepared for seeing the embryo . . . became very sad . . . I could clearly see that it would be a human being . . ."* [59] Another study described how "*The picture of the fetus was something they would never forget. "You could see fetus, where the ears were, the arms, I was really frightened."*[60] Given this information, this recommendation does not go far enough in ensuring practitioners use	consistency. Recommendation 1.2.7 states that healthcare professionals should inform women about what they should expect to see and what the pregnancy may look like when she passes it. This will differ depending on the gestation and therefore the committee agreed that this recommendation would prompt healthcare professionals to use their clinical judgement to give women the relevant information for their gestation. The language in evidence report B has been amended to be consistent with the recommendations.

[58] Evidence Review B, p. 42
[59] Evidence Review B, p. 63
[60] Evidence Review B, p. 69

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				accurate language to describe the fetus, ensuring that descriptions are not overly clinical and express the humanity in the fetus—a factor outlined in the evidence as causing women distress. **We therefore recommend** the following change: **For women who are having a medical termination of pregnancy, explain:** • **that they may see the fetus as they pass it** • **what the fetus will look like. This includes information about its size and that it may have the appearance of a developing human being.** **whether there may be any movement.**	
Christian Action Research and Education (CARE)	Guideline	12	18 - 24	We are concerned that this recommendation does not seem to align with the recommendations made in the 2010 RCOG guidance on termination of pregnancy for fetal abnormality, which makes recommendations regarding the information women should receive, the opportunity to discuss the options, and preparing parents for a potential live birth following a termination.[61] It does not consider the alternative care options that should be made clear to women, such as perinatal hospice nor recognise the grief that can be experienced in these circumstances. The 2013 Parliamentary Inquiry into Abortion on the Grounds of Disability also highlighted the experience of the information and guidance provided to families following the discovery of a	Thank you for your comment. The guideline is for people who have requested an abortion and covers safe and effective abortion care. The alternative options to abortion are outside the scope of this guideline. This information should be provided by the maternity service or fetal medicine specialist that diagnosed the fetal anomaly. Women wanting to know whether the fetus would experience pain during a termination did not emerge as a theme from the qualitative evidence review so the committee did not make recommendations about this. The HTA guidance on management and disposal of pregnancy remains contains information about registering births after 24 weeks and this is a legal requirement, therefore, the committee did not

[61] RCOG, Fetal Awareness Review of Research and Recommendations for Practice, March 2010

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				disability. The committee should note the information that women highlighted they wanted to know prior to a termination, such as receiving accurate communication of the diagnosis, as the ambiguity of results enhanced the anxiety and uncertainty in women.[62] This was particularly important given that some witnesses told the Commission about diagnoses they had received that had proved to be incorrect. Other women felt that there was a presumption on behalf of the medical profession that they would opt for an abortion.[63] Parents were sometimes only given a leaflet on abortion rather than information on support they would receive or on the condition that had been diagnosed.[64] Women also wanted to know whether the baby would experience pain during the procedure. One parent said: *"I never wanted him to be in pain, and part of the termination was, will he feel it, and they said he's going to feel it"*[65] Women also need to be made aware of the additional burden of birth registration following an abortion post 24 weeks.[66] The Inquiry further highlighted the need to make parents aware of palliative care as an option when they are considering whether to continue with the	make a recommendation about this. A reference to the Human Tissue Authority guidance has been added to the rationale.

62 2013 Parliamentary Inquiry into Abortion on the Grounds of Disability, p. 23
63 Ibid, p. 24
64 Ibid, p. 24
65 Ibid, p. 14
66 Ibid, p. 14

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				pregnancy after discover of a fetal disability.[67] The need for on-going longer term counselling for women in this scenario was stressed[68], particularly given the traumatic experience faced by the loss of an often much-wanted child.	
Christian Action Research and Education (CARE)	Guideline	12	18 - 25	We are concerned that this recommendation does not clarify the mental health issues that women may face, especially from losing a much-wanted baby. The committee discussed the need for support after a termination on the grounds of a fetal abnormality in Evidence Review O, stating that "*There was evidence that women may need support following termination of pregnancy for a number of reasons, including: dealing with isolation, negative feelings, milestones and the future, and to receive answers to specific questions and have someone validate their feelings.*"[69] This should alert the committee to the importance of ensuring abortion counselling is offered to women. However, the committee '*did not think it was appropriate to offer [post abortion] counselling as standard, despite this arising as a theme in the qualitative evidence, as some women do not feel they need support and may actually feel relieved after a termination of pregnancy and want to move on.*'[70] It is questionable why the	Thank you for your comment. The wording of the discussion in evidence report O has been amended to provide additional information about why the committee agreed it was not appropriate to offer everyone counselling as this may set the expectation that women will feel bad and need counselling, which could make them feel worse. However, recommendations 1.14.5 and 1.14.6 cover emotional support and counselling for women who would like this.

[67] Ibid, p. 26
[68] Ibid, p. 31
[69] Evidence Review O, p. 14
[70] Evidence Review O, p. 15

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				committee is ignoring this theme in the qualitative evidence, despite included studies pointing out that *"On some occasions it may be easier for women to be part of a system that guides them through managing their difficulties without them having to be asked if they want to be a part of it."*[71]	
Christian Action Research and Education (CARE)	Guideline	12	24	We are concerned that this recommendation suggests there is something negative about physical abnormalities, which women need assuring about. This could increase discriminatory attitudes towards those with congenital anomalies.	Thank you for your comment. This recommendation was included as the committee agreed that women may worry that the diagnosis they received was incorrect if there were not any physical signs of a fetal anomaly. The language has been amended in the recommendation and in the committee discussion in the evidence report to be more sensitive.
Christian Action Research and Education (CARE)	Guideline	12	24	In the light of our comments above, **we recommend** lines 24-25 should be replaced with the following: **Providers should:** • **Ensure the diagnosis is communicated impartially and accurately and that no pressure is placed on women to terminate** • **Ensure women are aware that there is a risk that the diagnosis may be incorrect** • **Give women detailed information about the diagnosis and how this may affect the appearance of the fetus** • **Ensure women are fully aware of all the options available for them, including**	Thank you for your comment. The guideline is for people who have requested an abortion and covers safe and effective abortion care. Therefore, information about a fetal anomaly is outside the scope of this guideline. This information should be provided by the maternity service or fetal medicine specialist that diagnosed the anomaly. The HTA guidance on management and disposal of pregnancy remains contains information about registering births after 24 weeks and this is a legal requirement, therefore, the committee did not make a recommendation about this. A reference to the Human Tissue Authority guidance has been added to the rationale.

[71] Evidence Review O, p. 33

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				support services and palliative care pathways • **Ensure that on-going, specialist counselling is available to women both before and after termination for a fetal anomaly.** **Inform women that they will need to register the birth if terminating after 24 weeks**	
Christian Action Research and Education (CARE)	Guideline	16	5	We are concerned that this recommendation suggests that medical termination at home will be suitable for everyone and carries no risk nor emotional consequences. We have already set out our concerns above about potential medical complications in our response to page 7, lines 10-12; and in our response to page 12 line 7 and the reaction of women who have passed a fetus at home. **We recommend** that this paragraph should include the words **"if clinically appropriate".** **We recommend** an additional paragraph. **Ensure women are fully informed of the risks of taking pills at home for a medical termination and are prepared to see the fetus on expulsion.**	Thank you for your comment. Recommendations in NICE guidelines should only be followed if it is clinically appropriate. Recommendation 1.2.2 states that women should be given information about the benefits and risks when choosing which method is most appropriate for them. Recommendation 1.2.7 highlights the need to tell women what to expect when having a medical abortion, including what they will see. The introductory text has been amend to remind healthcare professionals to provide information and obtain informed consent in line with General Medical Council guidance (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent) and the 2015 Montgomery ruling.
Christian Action Research and Education (CARE)	Guideline	16	12	We are concerned that this recommendation for women taking both abortion pills together goes against both the committee's own experience and evidence to the contrary of the benefits.	Thank you for your comment. The studies highlighted did not meet the inclusion criteria for the evidence review as they did not compare simultaneous to interval treatment. Evidence review H outlines that the committee agreed that

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				The committee express concern in Evidence Review H that *"the findings from this review did not correlate with their own experience or that from other non-RCT literature and noted that traditional regimens have a long, established practice whilst the evidence base for simultaneous ones is weaker."*[72] The risks of simultaneous administration of mifepristone with misoprostol have been evidenced in a number of studies. The Lohr 2007 study[73] found that administering misoprostol less than 24 hours after mifepristone led to a failure rate of 27% at under seven weeks gestation and 31% between 7-8 weeks gestation. Lohr et al concluded that simultaneous administration is therefore not recommended. A study by Guest et al[74] also found that simultaneous administration is not as effective at achieving a complete abortion as the protocol of 36-48 hours.	they could not offer a strong recommendation to adopt simultaneous regimens, but that it should be available as an option for women who would prefer it. However, this review question was developed when it was illegal to take misoprostol at home, which put a number of women at a disadvantage with the requirement of two visits to the clinic, e.g., those living in remote areas or vulnerable women. Therefore, with the change in the law (as also outlined in Evidence Review H) that now allows women to take misoprostol at home and removes the need for an additional appointment (which happened during development of this guideline), fewer women may opt for simultaneous treatment.
Christian Action Research and Education (CARE)	Guideline	16	12	We are concerned that this recommendation does not state that under the 2018 Approval of a Class of Places a woman has to take the first pill at a clinic. Paragraph 3(b) of the Approval allowing the second pill to be taken at home says that "the pregnant woman has taken the Mifepristone at the	Thank you for your comment. Both pills will need to be taken in clinic/hospital as per the law, and therefore this does not need to be explicitly stated. A reference to the Abortion Act, and other relevant legislation and guidance, has been included in the introductory text and a note has been added to remind healthcare professionals of their duty to

[72] Evidence Review H, p. 13
[73] Lohr et al, 2007. Oral mifepristone and buccal misoprostol administered simultaneously for abortion: a pilot study. https://www.ncbi.nlm.nih.gov/pubmed/17707719
[74] Guest et al, 2007. Randomised controlled trial comparing the efficacy of same-day administration of mifepristone and misoprostol for termination of pregnancy with the standard 36 to 48 hour protocol. https://www.ncbi.nlm.nih.gov/pubmed/17305893

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				clinic" and not exceeding nine weeks and six days.[75] Therefore the only setting where a woman can take both pills at the same time is in a clinic; a point acknowledged in Evidence Review H. [76] **We recommend** that at the start of line 15, there is an additional point added: **Both pills will need to be taken in a clinic or hospital**	work within the constraints of the law and ensure they are adhering to all applicable requirements.
Christian Action Research and Education (CARE)	Guideline	20	12 - 13	We are concerned that the recommendation to include remote assessment via text message will not uphold confidentially issues. **We recommend** that the reference to text messaging should be removed.	Thank you for your comment. The recommendations on follow up are about ensuring the successful completion of the abortion and are based on the evidence provided by 6 RCTs, which all showed that remote follow-up is a safe and acceptable alternative to in-clinic follow-up (for detail see Evidence Report I). Remote follow-up using text messaging or phone apps is already used by other services, e.g., chlamydia screening.
Christian Action Research and Education (CARE)	Guideline	25	16 - 21	We are concerned that the evidence does not make clear that neither counselling nor a waiting period is a legal requirement in England. **We recommend** that this be clarified as it implies all counselling can cause distress.	Thank you for your comment. This information has been added to the rationale and impact section for waiting times.
Christian Action Research and Education (CARE)	Guideline	40	3	We are concerned that the text here is out of line with the 2018 Approval of a Class of Places on taking the second pill at home since it says "medical termination at home is offered to women who take	Thank you for your comment. The evidence review addressed the question of the gestational age at which it is safe to pass a pregnancy at home. The evidence review did not address the

[75] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/768059/Approval_of_home_use_for_the_second_stage_of_early_medical_abortion.pdf
[76] Evidence Review H, p. 14

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				mifepristone before 10^{+1} week's gestation." Paragraph 3(b) of the Approval says that "the pregnant woman has taken the Mifepristone at the clinic" and not exceeding nine weeks and six days. [77] **We recommend** that the text be amended to be in line with the 2018 Approval of a Class of Places.	gestational age at which misoprostol can be taken at home, as this is specified in the in the 2018 Secretary of State approval order. However, the recommendations have been amended to clarify that women up to 9+6 weeks gestation can take the misoprostol at home (or in clinic/hospital) and expel the pregnancy at home but women at 10+0 will have to take the misoprostol in clinic before expelling the pregnancy at home.
Christian Medical Fellowship	Guideline	General	General	Please note that we suggest alternative or additional wording to replace, amend or add to the NICE draft guidance, with reasoning evidence provided for each proposal. Our alternative guidance wording is clearly highlighted as **bold blue text.** The rationale of the draft guidance is that an abortion is a right rather than a procedure that is permitted under the law only in certain circumstances. See pages 45-55 which states that: "*Termination of pregnancy is an integral part of reproductive health care for women… This guideline will help ensure that termination procedures are carried out based on the best available evidence, and that a choice of services is easily accessible to all women who request a termination of pregnancy*." We are concerned that no details are provided about the duty of commissioners and providers to	Thank you for your comments. The context section of the guideline has been amended to 'Abortion is a common procedure'. A statement has been added to the beginning of the document to remind healthcare professionals, patients and the public that all abortions must be performed within the legal framework set out by the Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990), and its related guidance. A reference to the Department of Health Required Standard Operating Procedures, and other relevant legislation and guidance, has also been included in the introductory text.

[77] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/768059/Approval_of_home_use_for_the_second_stage_of_early_medical_abortion.pdf

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				satisfy the requirements of the law. This should be the basis of the guidelines and reiterated throughout in order to ensure that the law is complied with. The Department of Health Required Standard Operating Procedure (RSOP) 1 states that: '*The law provides that, except in emergencies, two doctors must certify that in their opinion, which must be formed in good faith, at least one and the same grounds for abortion set out in the Act is met*.[78] Also, the Care Quality Commission (Registration) Regulations 2009, Human Medicines Regulations 2012 and regulations on the use of abortion pills at home all cover terminations. We are concerned that not all service providers, and certainly not service users, will be aware of the law and the legal framework surrounding abortion. **We recommend that references to the legal framework be more visible at all relevant points in the guidance.**	
Christian Medical Fellowship	Guideline	General	General	We are concerned that, from the settings listed in the scope, the time of 'Requesting termination of pregnancy' is not well delineated. The decision is usually a process over time, starting with an approach to a GP or abortion provider for a consultation, deciding to have the abortion and then actually proceeding with it or not. Clinical experience shows there may be a	Thank you for your comment. The guidance makes recommendations relating to the request for an abortion but the guideline scope does not cover how the woman makes that decision as this is covered by legislation and professional guidance. The 'this guideline covers' section has been amended to clarify the scope of this guideline and the introductory text has been

[78] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/313443/final_updated_RSOPs_21_May_2014.pdf

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				large degree of ambivalence at all points. A woman may have a consultation with a provider in order to explore the options and decide to proceed, but may continue with ambivalence and go back on that decision later on. We think this needs to be taken into account as the number of terminations carried out may increase substantially if this guidance assumes all requests are definitive or even autonomous at the point of first contact. It is clear from the draft wording of 1.1.1 and 1.1.2 (page 4, lines 4 and 9) that enabling the woman to reach the point at which she can 'request termination of pregnancy' is being *included* within the guidance. If that is NICE's approach then equally there must be more about information and counselling provision as a means to helping the woman make the request in a fully informed manner.	amended to refer to the Abortion Act and the Department of Health Required Standard Operating Procedures, which provide additional guidance relevant to helping women make a decision. The evidence identified in our review indicates that self-referral improves access and should result in abortions taking place at earlier gestations, and therefore with less complications. Our evidence review found that women want improved access. There is evidence (Cameron 2013) that most women (93%) are certain of their decision to not continue a pregnancy at the point at which they request an abortion. Therefore, once a women has requested an abortion she should not be faced with unnecessary delays due to the organisation of services. Wider global evidence (Guttmacher institute) also shows that improved access to abortion does not result in more abortions - but does result in safer abortion. However, recommendation 1.1.8 has been amended to say women should be provided with, or referred to support to make a decision if they request this.
Christian Medical Fellowship	Guideline	General	General	There is no guidance provided for women who change their minds <u>after</u> an initial decision to have a termination.	Thank you for your comment. This guideline focuses on the care that takes place in abortion services. If a woman decides she does not wish to have an abortion she will no longer be cared for by that service, and therefore falls outside the scope of this guideline. Recommendation 1.1.8 has been amended to say women should be provided with, or referred to support to make a decision if they request this, in

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					response to yours and others' comments. All healthcare professionals providing abortion services must work within the constraints of the law and must obtain informed consent for any medical/surgical procedure. A note has been added to the beginning of the document to remind healthcare professionals of their duty to do so
Christian Medical Fellowship	Guideline	4	4	**1.1.1 Commissioners and providers should work together to:** **• make information about termination of pregnancy services (including how to access them) widely available** **• ensure that women are promptly referred onwards if a service cannot provide a termination of pregnancy after a specific gestational age or by the woman's preferred method.** We are concerned that making information widely available about abortion services is outside the narrow entrance point set by NICE of 'requesting termination of pregnancy' - you do not need to tell people how to access a service that they have already accessed. Making information about termination of pregnancy services 'widely available' will reach women BEFORE the 'entrance point' and their decision making (as well as after) so this must be balanced with making information about alternative options widely available. In which case the guidance must correlate to both GMC and BMA guidance which encourages doctors to explain to patients the importance of knowing the	Thank you for your comment. The guidance makes recommendations relating to the request for an abortion but the guideline scope does not cover how the woman makes that decision as this is covered by legislation and professional guidance. The evidence identified in our review indicates that self-referral improves access & should result in abortions taking place at early gestations, and therefore with less complications. Our evidence review found that women want improved access and better information provision. Recommendation 1.1.8 has been amended to say women should be provided with, or referred to support to make a decision if they request this, in response to yours and others' comments. All healthcare professionals providing abortion services must work within the constraints of the law and must obtain informed consent for any medical/surgical procedure. A reference to the Department of Health Required Standard Operating Procedures, and other relevant legislation and guidance, has been included in the introductory text and a note has been added to the beginning of the document to remind healthcare professionals of their duty to ensure they are

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				options open to them while respecting a person's wish not to know. As noted in our general comment 2 above, even after the entrance point to the guidance, it cannot be assumed that the decision is final. NICE guidance must correlate with RSOP 14 which says: "*All women requesting an abortion should be offered the opportunity to discuss their options and choices with, and receive therapeutic support from, a trained pregnancy counsellor and* ***this offer should be repeated at every stage of the care pathway.***" Women should, as part of the information provision, and in order to ensure there is valid informed consent, be informed of possible adverse outcomes or complications of the procedure. **Montgomery ruled that doctors must spell out *any* (even tiny) material risks and any reasonable alternatives in dialogue with patients.**[79] For example, there is evidence of a small but real risk of physical complications from abortion, including subsequent preterm birth and for some women, a risk of mental health problems post abortion.[80]	adhering to all applicable requirements. The committee agree that it is necessary to fully inform women of risks associated with having an abortion but have not made exhaustive recommendations about this as it is part of good clinical practice and covered by professional guidance. The introductory text has been amended to remind healthcare professionals to provide information and obtain informed consent in line with General Medical Council guidance (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent) and the 2015 Montgomery ruling. The evidence for long-term health risks was not formally reviewed as part of this guideline. However, the committee agreed that a recommendation should be included that reassures women there is no increased risk of infertility, breast cancer and mental health problems as these are frequently mentioned despite the best available evidence showing that is not the case. The committee were aware that the Academy of Medical Royal Colleges guidance showed that following an unwanted pregnancy, there was not an increased risk of having mental health problems in women who had an abortion compared with those who gave birth. The committee acknowledge that there may be some

[79] Montgomery v Lanarkshire Health Board UKSC 11. 2015.

[80] The review into the mental health outcomes of induced abortion by the Academy of Medical Royal Colleges found that women with mental health problems before an abortion were at greater risk of mental health problems post abortion. It also found that other factors may be associated with increased rates of post-abortion mental health problems, such as a woman having a negative attitude towards abortions in general, being under pressure from her partner to have an abortion or experiencing other stressful life events.

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				It is therefore in the interest of providers to ensure that all women with an unplanned pregnancy have sufficient information about the different options, and the risks involved, before consenting to proceed with the option chosen. Our experience at CMF, working with members who have had well over 30 years of practice, is that around a third of women continue their pregnancies after being offered reassurance and help, and none have regretted this whereas many regret TOPs even decades later. **We would be willing to present our experiences to the Committee**. **If 'information on termination' is to be made 'widely available', then information on *alternatives* to termination must also be made widely available, as both will reach women prior to the entrance point as well as after. At minimum we propose referring to the DoH guidance for abortion providers, which states that women: 'must be given impartial, accurate and evidence-based information (verbal and written) delivered neutrally and covering:'** ■ Alternatives to abortion (for instance adoption and continuing with the pregnancy) ■ Abortion methods appropriate to gestation ■ The range of emotional responses that may be experienced during and following an abortion ■ What to expect during and after the abortion	evidence (although this was not reviewed as part of this guideline) of an association between abortion and risk of subsequent pre-term birth but agreed that the evidence for this is less definitive than for the risks discussed above and so did not make recommendations. The language in recommendation 1.2.1 has been amended to just mention infertility, breast cancer and mental health problems, not all long-term health risks.

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				(including potential side-effects, complications and any clinical implications). ■ Full discussion of contraception options and the supply of chosen method ■ Testing for sexually transmitted infections including HIV and strategies in place for infection prevention' Propose that the guidance additionally states: • **Make information about termination of pregnancy services, continuing with an unplanned pregnancy and adoption options (including how to access them) widely available** **Or** • **Make information about termination of pregnancy services and alternative pathways and options (including how to access them) widely available.** **And:** • **Women must be informed that they have a right to change their minds at any time, that the procedure can be postponed or cancelled and that they remain free to continue with the pregnancy, if they wish.**	
Christian Medical Fellowship	Guidance	4	9	**1.1.2 Commissioners and providers should allow women to self-refer to termination of pregnancy services.** We are concerned that this guidance is outside the narrow entrance point set by NICE of 'requesting termination of pregnancy'.	Thank you for your comment. The guideline makes recommendations relating to the request for an abortion but the guideline scope does not cover how the woman makes that decision as this is covered by legislation and professional guidance. The 'this guideline covers'

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				If self-referral takes place before the woman has made a request and decision on termination then this guidance is out of scope and should be removed (making an appointment with an abortion provider comes before the request for the termination) If the self-referral is to an abortion clinic after a request has been approved and complies with the law, then the guidance must clarify this, and stipulate that woman can only proceed with self-referral with a signed HSA form. We have the additional following concerns: If women self-refer, how does this meet the law's requirements that two doctors have separately formed the opinion, in good faith, that to continue the pregnancy would constitute a risk to the physical or mental health of the woman, greater than if the pregnancy were terminated? If women self-refer, how will it be ensured that a medical professional has provided objective gestational age dating? If women self-refer, how will it be ensured that there has been screening for medical and psychological contraindications?[81] If women self-refer, how will it be ensured that there is no coercion or intimate partner violence (IPV) for vulnerable women?	section has been amended to clarify the scope of this guideline. The evidence identified in our review indicates that self-referral improves access & should result in abortions taking place at early gestations, and therefore with less complications. Our evidence review found that women want improved access and better information provision. All healthcare professionals providing abortion services must work within the constraints of the law and must obtain informed consent for any medical/surgical procedure. A note has been added to the beginning of the document to remind healthcare professionals of their duty to do so. It is part of basic clinical care for healthcare professionals to ensure that women are not under physical or emotional duress and would form part of the assessment. The General Medical Council (https://www.gmc-uk.org/ethical-guidance/ethical-hub/adult-safeguarding) provides guidance about consent and coercion and a reference to this has been added to the introductory text of the guideline.

[81] https://www.aafp.org/afp/2006/0301/p925a.html

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				What is the evidence basis for this guidance? It is very poor and surveys find the opposite: 92% of women thought they should always be seen in person by a doctor when requesting an abortion.[82] In an ICM survey 38% of respondents said two doctors should see a woman compared to 15% who said no legal approval should be required, and 12% who said it should be one doctor, midwife or nurse.[83] **We propose that this guidance is removed as it is out of scope** **If it is not removed, then add:** • **Commissioners and providers should allow women to self-refer to termination of pregnancy services, after it is confirmed that the abortion is legally permitted, the relevant HSA forms are signed and she is screened for any medical contraindications**	
Christian Medical Fellowship	Guidance	4	11	**1.1.3 Healthcare professionals should not allow their personal beliefs to delay access to termination of pregnancy services.**	Thank you for your comment. This recommendation is consistent with professional guidance (e.g., the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-

[82] https://www.comresglobal.com/wp-content/themes/comres/poll/Christian_Institute_Abortion_Survey_3rd_March_2014.pdf
[83] https://www.icmunlimited.com/wp-content/uploads/2017/10/OlOm-Abortion-Documentary-v2.pdf

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				If a request for termination does not fulfil the parameters of the law, the healthcare professional should not refer a woman for a termination. Professionals may have a valid reason not to participate or refer a woman and declining or delaying access does not imply stigma nor may it be a reflection of personal beliefs but that abortion is not clinically indicated. If a healthcare professional does hold personal beliefs that are opposed to termination, s/he has the right to exercise his/her freedom of conscience in this. As long as the woman has the information she needs (as per GMC guidance), the healthcare professional has fulfilled his/her responsibility within the law. S/he should not be required to go against her conscience. The UK Equality Act (2010) prohibits direct or indirect discrimination on the grounds of religion and belief, amongst other grounds. It is strongly arguable that the 'philosophical belief' in the sanctity of life from conception would be protected under its provisions. A clinician holding this belief, whether for religious reasons or otherwise, and who is required by her professional body to refer her patient for a procedure that is at odds with her convictions, would therefore have a case under the terms of the Equality Act. Following a recent European Court of Human Rights decision, ([2013] IRLR 231) the protection afforded under Article 9 of the European Convention of Human Rights (ECHR) has been expanded to protect 'a practice or manifestation	medical-practice) as healthcare professionals have a right to their personal beliefs and to opt out of performing a procedure, but cannot opt out of providing access. A statement has been added to the guideline to remind healthcare professionals that all care must be given within the constraints of the Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990). Additional information has been added to the rationale to clarify this. Recommendation 1.1.8 has been amended to say women should be provided with support to make a decision if they request this. It is outside the remit of a NICE guideline to comment on individual CQC findings.

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				motivated, influenced or inspired by religion or belief....regardless of whether it is a mandatory requirement of the religion or belief'. Further, the Court determined that the availability of alternative employment in the workplace, that would accommodate the employee's beliefs, is no longer to be a limiting factor. Thus healthcare professionals may well be able to claim that to be 'required' to participate in the process would make them complicit in any subsequent abortion and would discriminate against them under the terms of the ECHR. We are concerned therefore that this recommendation will place undue pressure on medical staff with conscientious objection to refer women to termination. We have concerns that some healthcare professionals may allow their personal beliefs to pressure women into accessing termination of pregnancy services more quickly than they are comfortable with, which is a particular concern if the woman is ambivalent at all. There is evidence already that this is happening. A report on MSI clinics by the CQC said that women who had decided not to have an abortion – and were less than five and a half weeks pregnant – 'were being called and offered a later appointment'. Inspectors found evidence that this was a policy across all 70 Marie Stopes clinics in the UK where key	

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				performance indicators were used and abortions were linked to bonuses. [84] The following proposed wording provides a necessary balance to the current draft: • **Healthcare professionals should not allow their personal beliefs (or an employer) to pressure a woman into having an abortion but must ensure she knows she is able to change her mind at any time** • **Healthcare professionals must ensure that a termination is clinically indicated and within the law** **Healthcare professionals who want to exercise their conscientious objection to providing or referring women to termination should follow professional guidance such as the GMC.**	
Christian Medical Fellowship	Guidance	4	13	RSOP 14 states that '*Care pathways to antenatal services for those who choose to continue their pregnancy, and for women considering adoption, should be in place.*' If funding is provided for terminations for eligible women, it should be provided for antenatal care.	Thank you for your comment. It was not within the scope of this guideline to make recommendations for women who decide to continue with pregnancy. A reference to the Department of Health Required Standard Operating Procedures, and other relevant legislation and guidance, has been included in the introductory text.

[84] MSI "staff were concerned that 'Did Not Proceed', the term used when women decided not to proceed with treatment, was measured as a KPI [key performance indicator] and linked to their performance bonus. They felt that this encouraged staff to ensure that patients underwent procedures." Staff were concerned that this created "a culture that worked against patient choice," said the report. "One staff member described it as 'feeling like a hamster in a wheel' and said the word, 'Cattle market' came up quite a lot. https://www.dailymail.co.uk/news/article-4998810/Britain-s-largest-abortion-clinic-paid-staff-bonuses.html?login&base_fe_url=http%3A%2F%2Fdailymail.co.uk%2F&validation_fe_uri=%2Fregistration%2Fp%2Fapi%2Ffield%2Fvalidation%2F&check_user_fe_uri=registration%2Fp%2Fapi%2Fuser%2Fuser_check%2F&isMobile=false#newcomment

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				All options must be supported. Unless funding for all options is offered upfront, for women who need it, there is a clear message that the preferred option is termination. **Commissioners should consider upfront funding for travel and accommodation for women who are eligible who have changed their mind about a termination and are considering continuing the pregnancy and either keeping the baby or placing it for adoption.**	
Christian Medical Fellowship	Guidance	4	18	The evidence for this is limited and the recommendation here for minimal delay is not backed up by the evidence cited. More common reasons for later terminations are not delays in access but women's uncertainty in the decision or not realising they were pregnant. Decisions on termination for some women can be difficult and require time to think, not pressure to make quick decisions.	Thank you for your comment. Evidence report A outlines both the evidence that mortality increases with every additional week of gestation and the barriers to accessing service. The recommendations in this guideline aim to reduce unnecessary delays once a women has requested an abortion. Recommendation 1.1.7 was included to ensure that women can wait longer to have an abortion if they would prefer this for whatever reason, including if she is still considering her options. Recommendation 1.1.8 has also been amended to say women should be provided with, or referred to support to make a decision if they request this. The rationale has been expanded to clarify this.
Christian Medical Fellowship	Guidance	4	21	**1.1.6 Ensure minimal delay in the termination of pregnancy process, and ideally:** • **provide the assessment within 1 week of the request**	Thank you for your comment. This guideline does not cover the time period before a women has requested an abortion and there is evidence (Cameron 2013) that most women (93%) are certain of their decision to not continue a

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				• **provide the termination of pregnancy within 1 week of the assessment.** Evidence shows that women overwhelmingly support waiting periods between an initial consultation and an abortion taking place – in polls 79% agree compared to 9% who disagree with this.[85] (While this poll is not a pure subset of women having terminations, it will include many women who have had terminations and these guidelines should recognise that abortion research is unusual due to the emotional and highly personal nature of the procedure and its implications. As a result, many women will have views and experiences but not want to talk about them. Data from follow ups after abortion may be skewed as women with negative experiences may be keen to forget them and move on, whereas those who are keen or willing to engage in follow up are more likely to be those with a positive view of abortion in general. Hence the value in qualitative research as well as polling data and quantitative data) Peer reviewed evidence also warns that: *'Hasty early abortions as well as delayed abortions create problems and should be avoided.'* [86] And some women find the decision to terminate "*difficult and reported that it took them time to*	pregnancy at the point at which they request an abortion. Therefore, once a women has requested an abortion she should not be faced with unnecessary delays due to the organisation of services. However, recommendation 1.1.7 was included to ensure that women can wait longer to have an abortion if they would prefer this for whatever reason, including if she is still considering her options. Recommendation 1.1.8 has also been amended to say women should be provided with, or referred to support to make a decision if they request this. The rationale has been expanded to clarify this. A reference to the Department of Health Required Standard Operating Procedures, and other relevant legislation and guidance, has been included in the introductory text. It is outside the remit of a NICE guideline to comment on individual CQC findings.

[85] https://www.comresglobal.com/wp-content/uploads/2017/05/Where-Do-They-Stand-Abortion-Survey-Data-Tables.pdf Q6.
[86] Holmgren et al, 'Ambivalence during Early Pregnancy among Expectant Mothers', Gynecol Obstet Invest 1993;36:15–20

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				decide to proceed with it." [87] See also Ingham et al.[88] Despite the regulation in RSOP 8 that consent must '*Be provided voluntarily and without undue pressure on the woman to accept or refuse treatment*', this draft guidance could put undue pressure on women to proceed quickly. There is evidence already that this is happening. A report on MSI clinics by the CQC said that women who had decided not to have an abortion – and were less than five and a half weeks pregnant – 'were being called and offered a later appointment'. Inspectors found evidence that this was a policy across all 70 Marie Stopes clinics in the UK where key performance indicators were used and abortions were linked to bonuses. [89] For balance, and based on evidence, the guidance needs not just to focus on speeding up the abortion process but must ensure women do	

[87] This is of women who had awareness of their pregnancy at an early stage. Marie Stopes International. Late Abortion: A Research Study of Women Undergoing Abortion between 19 and 24 Weeks Gestation. London, MSI, 2005

[88] '…for *all age groups and gestations, most reasons for delay are best considered "woman-related" – i.e. delays in suspecting and confirming the pregnancy and in* ***deciding to have an abortion*** *–* ***rather than "service-related"****. This suggests, for England and Wales at least, limits on the extent to which policy changes directly related to early abortion services can be expected to reduce the proportion of second trimester abortions. This conclusion may come as a surprise;* ***it has been a long-held assumption in the British abortion debate that making early abortion more accessible is the best way to reduce demand for second trimester procedures."*** Ingham et al, 'Reasons for Second Trimester Abortions in England and Wales', *Reproductive Health Matters*, 2008, 16:sup31, 18-29.

[89] MSI "staff were concerned that 'Did Not Proceed', the term used when women decided not to proceed with treatment, was measured as a KPI [key performance indicator] and linked to their performance bonus. They felt that this encouraged staff to ensure that patients underwent procedures." Staff were concerned that this created "a culture that worked against patient choice," said the report. "One staff member described it as 'feeling like a hamster in a wheel' and said the word, 'Cattle market' came up quite a lot. https://www.dailymail.co.uk/news/article-4998810/Britain-s-largest-abortion-clinic-paid-staff-bonuses.html?login&base_fe_url=http%3A%2F%2Fdailymail.co.uk%2F&validation_fe_uri=%2Fregistration%2Fp%2Fapi%2Ffield%2Fvalidation%2F&check_user_fe_uri=registration%2Fp%2Fapi%2Fuser%2Fuser_check%2F&isMobile=false#newcomment

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				not make too hasty a decision and that there is no undue pressure on women. Even if a woman has been offered a termination, and fits the legal criteria, as with any medical operation, some women will change their minds about it, and this must be made clear to all women. Add in following guidance: • **Ensure women know that they can change their minds at any time, and have the procedure postponed or cancelled at any time if she wants to continue with the pregnancy.**	
Christian Medical Fellowship	Guidance	5	1	**1.1.7 For women who would prefer to wait longer for a termination of pregnancy, explain the implications so they can make an informed decision.** NICE guidance must correlate with **DoH RSOP guidance 14** which states that if a woman is ambivalent (following counselling) she '*can be given a provisional appointment for admission but must be told that the procedure can be postponed or cancelled and that she remains free to continue with the pregnancy, if she so wishes.'* There is also currently no mention of making women aware of alternative pathways, which was highlighted in **RSOP 14:** '*Care pathways to antenatal services for those who choose to continue their pregnancy, and for women considering adoption, should be in place*.'	Thank you for your comment. There is evidence (Cameron 2013) that most women (93%) are certain of their decision to not continue a pregnancy at the point at which they request an abortion, and therefore once a women has requested an abortion she should not be faced with unnecessary delays due to the organisation of services. Recommendation 1.1.7 was included to ensure that women can wait longer to have an abortion if they would prefer this for whatever reason, including if she is still considering her options. Recommendation 1.1.8 has also been amended to say women should be provided with, or referred to support to make a decision if they request this. The rationale has been expanded to clarify this. A reference to the Department of Health Required Standard Operating Procedures, and other relevant legislation and guidance, has

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				Women may decide to follow this route even <u>after</u> an initial decision for termination. Requests to wait longer for termination generally reflect ambivalence which makes women more vulnerable to long-term mental health issues. Women overwhelmingly support waiting periods between an initial consultation and an abortion taking place – 79% agree compared to 9% who disagree with this.[90] NICE must ensure that MSI and other clinics do not pressure women into making decisions quickly or stopping them from changing their minds, as has been widely reported. To make an informed decision women must be told of **alternative pathways** and: • **Explain to women that they can change their minds at any time and the procedure postponed or cancelled.** **Ensure that provision is put in place to prevent pressurising women who may be ambivalent to having a termination**	been included in the introductory text and a note has been added to the beginning of the document to remind healthcare professionals of their duty to ensure they are adhering to all applicable requirements.
Christian Medical Fellowship	Guidance	5	4	**1.1.8 Do not require women to have compulsory counselling or compulsory time for reflection before the termination of pregnancy.**	Thank you for your comment. Recommendation 1.1.7 was included to ensure that women can wait longer to have an abortion if they would prefer this for whatever reason, including if she is still considering her options. Recommendation 1.1.8 has also been amended to say women should be

[90] https://www.comresglobal.com/wp-content/uploads/2017/05/Where-Do-They-Stand-Abortion-Survey-Data-Tables.pdf

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				We are concerned that this recommendation implies negativity towards counselling and may deter women from accessing it. There is evidence that many women have ambivalence in their decision-making and will change their minds.[91] [92] The process towards termination must include opportunity for women to change their minds and to be given the opportunity to reflect on the decision and to discuss the decision at any time (as with any medical operation) as a decision may not be a settled decision. As currently drafted, this implies counselling and reflection are unimportant, indeed unhelpful. Our experience at CMF, working with members who have had well over 30 years of general practice, is that around a third of women continue their pregnancies after being offered reassurance and help, and none have regretted this whereas many regret terminations even decades later. **We would be willing to present our experiences to the Committee**.	provided with, or referred to support to make a decision if they request this. The rationale has been expanded to clarify this. However, the committee agreed it was not appropriate to offer everyone counselling, as this may set the expectation that women will feel bad and need counselling, which could make them feel worse. Further, the committee were aware that the Academy of Medical Royal Colleges guidance showed that following an unwanted pregnancy, there was not an increased risk of having mental health problems in women who had an abortion compared with those who gave birth. A reference to the Department of Health Required Standard Operating Procedures, and other relevant legislation and guidance, has been included in the introductory text.

[91] Ingham et al, p. 25
[92] Husfeldt et al, 'Ambivalence among women applying for abortion', Acta Obstet Gynecol Scand. 1995 Nov;74(10):813-7.

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				For cases where there may be coercion, or IPV, an opportunity for counselling could be essential to safeguard women. **Counselling must** be **offered, although the woman should be free to decline it**. We propose a reword of this provision to correlate to RSOPs 8 and 14[93] and DoH guidance with NICE guidance. DoH RSOP regulations state that every woman who requests an abortion 'should be offered' the opportunity to discuss her options and choices with a 'trained pregnancy counsellor'.[94] 'A trained pregnancy counsellor is someone trained to Diploma level. Counselling must be non-directive and non-judgmental and should not create barriers or delays. Counsellors should undergo continuous professional development and training similar to other professionals.' RSOP 14 says "*All women requesting an abortion should be offered the opportunity to discuss their options and choices with, and receive therapeutic support from, a trained pregnancy counsellor and* ***this offer should be repeated at every stage of the care pathway.****"* There also needs to be informed consent, RSOP 8.	

[93] "*All women requesting an abortion should be offered the opportunity to discuss their options and choices with, and receive therapeutic support from, a trained pregnancy counsellor and this offer should be repeated at every stage of the care pathway*."

[94] Department of Health. Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion). London: DH; 2014:24. bit.ly/1PJlqy1.

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				Research shows that women can sometimes suffer harm – particularly psychological harm – post-abortion and this may be compounded if there is ambivalence or pre-existing mental health problems, or other factors. If such women are rushed into a decision without time to reflect, these will be compounded. RSOP guidance states that if a woman is ambivalent (albeit following counselling) she '*can be given a provisional appointment for admission but must be told that the procedure can be postponed or cancelled and that she remains free to continue with the pregnancy, if she so wishes*.' (RSOP 14) **At every stage of the pathway women must be offered the opportunity to discuss all her options and choices with a trained pregnancy counsellor, who is non-directive, and to be able to take time to reflect on the decision if she wishes.**	
Christian Medical Fellowship	Guidance	5	7	**1.1.9 Consider providing termination of pregnancy consultations by phone or video call, for women who prefer this.** RSOP 14: *'Clinicians caring for women requesting abortion should be able to identify those who require more support than can be provided in the routine abortion service setting, for example young women, those with a pre-existing mental health condition, those who are subject to sexual violence or poor social support, or where there is evidence of coercion*.'	Thank you for your comment. It is part of basic clinical practice for healthcare professionals to be alert for signs of physical or emotional abuse or coercion, and therefore not necessary to make a specific recommendation in this guideline. The committee recommended phone or video call assessments as they could help women that are under pressure from families or abusive partners to access services remotely that they would otherwise not be able to do, as well as other reasons for not being able to access services such

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				How can this RSOP be complied with by a phone call? A telephone consultation is inadequate, particularly to ensure there is no coercion from another person. IPV is a consistent and strong risk factor for unintended pregnancy and abortion across a variety of settings.[95] The problem of coercion and forced abortion is becoming more commonplace in the UK. Whilst coercion is chiefly carried out by intimate partners, it can also be initiated from a host of sources, including wider family, friends, health-workers or employers. Coercion can manifest in threats of violence, emotional blackmail and continuous pressure to undergo an abortion. Research by polling company D-Cyfor recently revealed that 7% of UK women have been forced to undergo an abortion.[96] UK healthcare professionals need to be *more*, not less, vigilant in screening for coercion. CQC Inspectors found evidence that pressure to have an abortion was common across Marie Stopes clinics in the UK where key performance indicators	as location. Clinicians conducting an assessment remotely have a duty of care to cover the same aspects, including medical history and safeguarding concerns, as they would in a face to face consultation. However, there was not a review question about content of assessment within this guideline and so further detail on what should be included cannot be provided. A reference to the Department of Health Required Standard Operating Procedures, and other relevant legislation and guidance, has been included in the introductory text and a note has been added to the beginning of the document to remind healthcare professionals of their duty to ensure they are adhering to all applicable requirements. It is outside the remit of a NICE guideline to comment on individual CQC findings.

[95] https://www.ncbi.nlm.nih.gov/pubmed/22959631

[96] https://www.independent.co.uk/news/uk/home-news/pregnancy-coercion-reproduction-abortion-a8834306.html

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				were used and abortions were linked to bonuses.[97] This guidance ignores overwhelming opinion of women (92% according to a ComRes survey) that a woman requesting an abortion should always be seen in person by a qualified doctor.[98] Moreover the health of women considering an abortion will be put at risk otherwise and surveys concur: most women (73%) think the health of women will be put at risk unless the doctor who signs the abortion sees the patient in person.[99] This guidance also raises concerns about safeguarding of patient confidentiality and data protection (RSOP 6) - how is text messaging considered confidential? Or indeed video calls? **We propose removing this guidance or at least modifying it to ensure vigilance against coercion**	

[97] MSI "staff were concerned that 'Did Not Proceed', the term used when women decided not to proceed with treatment, was measured as a KPI [key performance indicator] and linked to their performance bonus. They felt that this encouraged staff to ensure that patients underwent procedures." Staff were concerned that this created "a culture that worked against patient choice," said the report. "One staff member described it as 'feeling like a hamster in a wheel' and said the word, 'Cattle market' came up quite a lot. https://www.dailymail.co.uk/news/article-4998810/Britain-s-largest-abortion-clinic-paid-staff-bonuses.html?login&base_fe_url=http%3A%2F%2Fdailymail.co.uk%2F&validation_fe_uri=%2Fregistration%2Fp%2Fapi%2Ffield%2Fvalidation%2F&check_user_fe_uri=registration%2Fp%2Fapi%2Fuser%2Fuser_check%2F&isMobile=false#newcomment

[98] https://www.comresglobal.com/wp-content/themes/comres/poll/Christian_Institute_Abortion_Survey_3rd_March_2014.pdf

[99] https://www.comresglobal.com/wp-content/uploads/2017/05/Where-Do-They-Stand-Abortion-Survey-Data-Tables.pdf

Consultation on draft guideline - Stakeholder comments table
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Christian Medical Fellowship	Guidance	5	9	**1.1.10 Consider providing termination of pregnancy services in a range of settings (including in the community and in hospitals), according to the needs of the local population.** What is the evidence base for this proposal considering that: *'Non-RCT evidence showed there was no clinically important difference between the time between referral and assessment in the 'community services' group and the 'hospital services' group'*[100] ? There is no explanation of what 'community' entails? Is it Schools? Colleges? Sexual health clinics? homes? **If this guidance is not removed**, then clarification is required that Government guidelines permit only *misoprostol* to be taken at home only up to 9 week + 6 days gestation at the time *mifepristone* is taken.[101] **Clarify what 'community' entails and what locations in the community comply with the legal requirement that terminations be carried out in an 'approved' place.** DoH RSOP 2 states*: 'Under Section 1(3) of the Abortion Act 1967 treatment for EMA can only take place in a NHS hospital or approved independent sector place. The courts have decided that this means that both drugs (mifepristone and misoprostol) for the medical*	Thank you for your comment. There was no evidence from the quantitative review that community services reduced waiting times. However, there was some evidence that patient satisfaction may be higher with community services compared with hospital services. There was good evidence from the qualitative review that travel arrangements can cause delays to accessing abortion services and that community prescribing for either has, or would, improve access to abortion services, increase flexibility and facilitate a more woman-centred approach to care. So when the qualitative and quantitative evidence were considered together, the committee agreed that community services may improve access. This is explained in the discussion in evidence report A. Community services in the context of abortion refers to abortion clinics and services that are provided outside the hospital setting and are approved by the Secretary of State for Health and Social Care. A reference to the Abortion Act and the Department of Health Required Standard Operating Procedures, and other relevant legislation and guidance, has been included in the introductory text and a note has been added to remind healthcare professionals of their duty to work within the constraints of the law and ensure they are adhering to all applicable requirements.

[100] Evidence Review A, p. 30

[101] Approval of home use for the second stage of early medical abortion, Dec 2018
https://www.rcog.org.uk/globalassets/documents/guidelines/early-medical-abortion-at-home-guideline-england.pdf

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				abortion must be taken in the hospital or approved place.' Add in the following guidance: • ***mifepristone* must be taken in a NHS hospital or approved independent sector place** • **Clarify this applies for pregnancies up to 9 week + 6 days gestation at the time *mifepristone* is taken.** When terminations take place outside medical centres, it removes medical information, supervision and support for what is a medical procedure. While this is of concern for all women it is particularly so with **teenage girls or other vulnerable women.** Women with learning difficulties or co-existing medical or mental health conditions, who may struggle to understand or interpret guideline recommendations for medicines, will also be vulnerable where the trend is towards home-based abortions. Minors being sexually abused will be more easily missed if the age of the father is not inquired about. Nearly all the major reports on sexual abuse (eg Rochdale, Oxford, etc) all implicate doctors and abortionists for not asking the questions they should. The problem is that outside of medical supervision, there is no control over *when*, *where* or even *who* is taking the pills. Taking such strong drugs is not to be taken lightly; in trials, *almost all women* using *mifepristone* for medical abortions experienced abdominal pain or	Clinicians working in community services have the same duty of care as clinicians working in hospitals to assess whether there are any medical or safeguarding concerns. NICE guidelines are intended as guidance only and not to override clinical judgement or issues that may not make it appropriate for an individual. However, with the options of home expulsion, taking misoprostol at home after an interval of 24-48 hours, and of self-assessment/remote follow-up, the guideline recommendations introduce more flexibility in abortion care that should make it easier for women who have to travel to access services. Moreover, the guideline includes an evidence-based recommendation about taking mifepristone and misoprostol simultaneously for abortions up to 9 weeks, which specifies that vaginal misoprostol is used. For abortions up to 9+6 weeks' gestation where an interval regime is used and the misoprostol is taken at home (as now permitted by law), the misoprostol will be accompanied with clear instructions about how and when to take it as well as information about potential side effects and complications as this is also all part of the women providing informed consent to the procedure in the first place. The introductory text has been amended to remind healthcare professionals to provide information and obtain informed consent in line with General Medical Council guidance (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent) and the 2015 Montgomery ruling.

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				uterine cramping; and a significant number experienced nausea, vomiting, and diarrhoea. For many, the outcomes are worse (see comments below). Where adequate safety and support system resources are limited, for example for those living in remote areas, home-based abortions should not be offered. Surgical abortion is an option for those who cannot get home before bleeding begins, or those who cannot access medical services quickly after the abortion. Add in new guidance: • **Consider if this is appropriate or in the best interests of young and/or vulnerable women.** • **Where women have transport problems, medical abortion is contra indicated and surgical abortion should be provided instead.** **A further concern with removing the medical supervision is that the precise time interval** between taking *mifepristone* and taking *misoprostol* is critically important in the effectiveness of the regimen and directly affects how likely the woman is to experience a failed drug-induced abortion and require subsequent surgery. *Misoprostol* is recommended to be taken 24 to 48 hours after taking *mifepristone,* otherwise	

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				its effectiveness is significantly lowered,[102] with one study finding that nearly one out of every three to four women who took buccal *misoprostol* shortly after *mifepristone* **failed to abort**.[103] Yet there is nothing to stop a woman taking this outside the recommended hours if she is outside of medical supervision. Research has shown that women have a strong preference for a short time interval between the *mifepristone* and misoprostol, and consequently may well be inclined to take it quicker.[104] For women who are *over seven weeks* gestation (when medical abortions are most commonly used) the **failure rate was up to 31%**.[105] Removing medical supervision over the timing of *misoprostol* administration, allowing women take it at a time 'convenient for them', will increase failure rates, complications (including infection) and need for subsequent surgery.	
Christian Medical Fellowship	Guidance	5	13	**1.1.11 Termination of pregnancy providers should maximise the role of nurses and midwives in providing care.**	Thank you for your comment. A reference to the Abortion Act and the Department of Health Required Standard Operating Procedures, and other relevant legislation and guidance, has been

[102] https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf
[103] https://www.ncbi.nlm.nih.gov/pubmed/17707719
[104] https://www.acog.org/-/media/Practice-Bulletins/Committee-on-Practice-Bulletins----Gynecology/Public/pb143.pdf?dmc=1
[105] https://www.ncbi.nlm.nih.gov/pubmed/17707719

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				92% of women thought they should always be seen in person by a doctor when requesting an abortion.[106] In an ICM survey 38% of respondents said two doctors should see a woman compared to 15% who said no legal approval should be required, and just 12% who said it should be one doctor, midwife or nurse.[107] Again, the guidance needs to clarify the legal context to ensure it is complied with, particularly the prescribing role of the two RMPs. RSOP 1 states: *The Abortion Act 1967 regulates the provision of abortion services in England, Wales and Scotland. If an abortion is performed which does not comply with the terms of the Act then an offence will have been committed under the Offences Against the Person Act 1861 and /or the Infant Life (Preservation) Act 1929.* *The law provides that, except in emergencies, two doctors must certify that in their opinion, which must be formed in good faith, at least one and the same grounds for abortion set out in the Act is met.* Nurses and midwives must be permitted to exercise their right to refuse involvement in any	included in the introductory text and a note has been added to remind healthcare professionals of their duty to work within the constraints of the law and ensure they are adhering to all applicable requirements. The committee agreed that it was not necessary to specify that nurses and midwives can have a conscientious objection to participating in abortion care as this is a legal requirement that applies equally to all healthcare professionals and is covered by professional guidance (e.g. the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice).

[106] https://www.comresglobal.com/wp-content/themes/comres/poll/Christian_Institute_Abortion_Survey_3rd_March_2014.pdf
[107] https://www.icmunlimited.com/wp-content/uploads/2017/10/OlOm-Abortion-Documentary-v2.pdf

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				abortion procedures on the grounds of conscience. [108] Include: • **Termination of pregnancy providers should maximise the role of nurses and midwives in providing care, provided that two registered medical practitioners have certified that the abortion request meets the legal criteria.** • **Ensure the rights of nurses and midwives to exercise their freedom of conscience under the Equality Act are protected**	
Christian Medical Fellowship	Guidance	5	15	**1.1.12 Trainee healthcare professionals who may care for women who request a termination of pregnancy (for example nurses, midwives, and GPs) should have the chance to gain experience in termination of pregnancy services during their training**. It is of paramount importance that there is no pressure for conscientiously objecting doctors or other medical staff to engage with the training. There is evidence that conscientiously objecting doctors are liable to perform them due to pressure within work.[109] In particular, there is evidence that	Thank you for your comment. The committee did not think this recommendation needed expanding as it is consistent with professional guidance (e.g., the General Medical Council guidance https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent) and it is not the focus of this guideline to provide further guidance on this. Whilst the guideline makes recommendations about the principles under which training should be delivered, the specific content of training is beyond the scope of NICE guidelines.

[108] The UK Equality Act (2010) prohibits direct or indirect discrimination on the grounds of religion and belief, amongst other grounds. It is strongly arguable that the 'philosophical belief' in the sanctity of life from conception would be protected under its provisions. A clinician holding this belief, whether for religious reasons or otherwise, and who is required by her professional body to refer her patient for a procedure that is at odds with her convictions, would therefore have a case under the terms of the Equality Act.

[109] Strickland, JME, 2011 shows significant discrepancy between those who have an objection to the procedure and those who would refuse to perform it.

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				Muslim doctors are pressured to go against their religious beliefs (anecdotal evidence from BIMA, and Strickland 2011 shows discrepancy for Muslims in particular). Please add in the following words to this guidance: • **Trainee healthcare professionals who may care for women who request a termination of pregnancy (for example nurses, midwives, and GPs) should have the OPPORTUNITY to gain experience in termination of pregnancy services during their training IF THEY WISH** We recommend comprehensive teaching on the law and ethics of abortion developed jointly by pro-choice and pro-life clinicians to fairly represent the range of views within the medical profession. We also recommend the same for nursing students, and recommend that this includes information on clinical assessment for whether they meet the legal criteria, in line with the best evidence on physical and mental health. We recommend also accurate resources made available for doctors who want to practise in accordance with their faith. • **Training in termination of pregnancy services must include teaching on the law and ethics of abortion, including both pro-abortion and pro-life views**	

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Christian Medical Fellowship	Guidance	6	1	**1.1.14 If a trainee's placement service does not provide termination of pregnancy, the trainee should gain experience with whoever is providing this service (either in the NHS or in the independent sector).** • **Trainee healthcare professionals who may care for women who request a termination of pregnancy should have the opportunity to opt-into training if they wish**	Thank you for your comment. The previous recommendation states that trainees can opt-out of abortion training under the grounds of conscientious objection. Therefore, recommendation 1.1.14 follows on from this to explain that if they have not opted out but their placement does not provide abortions then they should be given the opportunity to gain this experience in an alternative service.
Christian Medical Fellowship	Guidance	6	8	**1.1.16 Providers should develop pathways for women with complex needs or significant comorbidities to:** NICE guidance must correlate with **DoH RSOP guidance 14** which states that if a woman is ambivalent (following counselling) she '*can be given a provisional appointment for admission but must be told that the procedure can be postponed or cancelled and that she remains free to continue with the pregnancy, if she so wishes.'* RSOP 14 also details the extra care required for women who need more support. Accordingly, we propose an additional requirement based on RSOP 14: • **refer them to specialist centres if needed** • **minimise delays in accessing care** • **avoid the need for women to repeat key steps (such as returning to their GP for**	Thank you for your comment. The guideline is for people who have requested an abortion and covers safe and effective abortion care. The alternative options to abortion are outside the scope of this guideline. Women have the right to change their mind and clinicians should follow professional guidance (e.g., the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent) to ensure that women are not being coerced to make a decision. A reference to the Department of Health Required Standard Operating Procedures, and other relevant legislation and guidance, has been included in the introductory text and a note has been added to the beginning of the document to remind healthcare professionals of their duty to ensure they are adhering to all applicable requirements.

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				referral, or repeated assessments or investigations). • **Ensure that women are aware of alternative pathways and have the opportunity to change their minds at any point before the termination and be informed that the procedure can be postponed or cancelled and that she remains free to continue with the pregnancy, if she so wishes.** • **Services should have referral pathways in place with access to trained counsellors with appropriate expertise**	
Christian Medical Fellowship	Guidance	6	15	**1.1.17 When caring for women who are having a termination of pregnancy, be aware of:** • **the anxiety they may have about perceived negative and judgemental attitudes from healthcare professionals** • **the impact that verbal and non-verbal communication may have on them.** Medical practitioners have to be able to justify in good faith that the legal requirements for an abortion request are complied with, and they have to do so through the whole process from request to termination It would therefore be appropriate to communicate the legal requirements to women when necessary. If a medical practitioner does not believe in good faith that one of the legal requirements is being fulfilled (for example if there are pre-existing mental health factors that would	Thank you for your comment. Satisfying whether the legal conditions for an abortion have been met is not the focus of this recommendation. Rather, it is in response to evidence that how some healthcare professional communicate with women can be a barrier to accessing services. It is part of basic clinical practice for healthcare professionals to be alert for signs of physical or emotional abuse or coercion, and therefore not necessary to make a specific recommendation in this guideline as this is covered by professional guidance (e.g., the General Medical Council guidance https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent). The introductory text of the guideline has been amended to make reference to this. There is evidence (Cameron 2013) that the majority of women are sure of their decision to proceed at the point of requesting a

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				be exacerbated by an abortion, or if there is coercion, or if an abortion may not be taking place in an approved place) s/he has a duty under the law not to sign the forms or proceed with termination. This is about fulfilling the law, not perceived judgemental attitudes. Moreover anxiety for women is caused by a wide variety of factors, including coercion and ambivalence towards the termination. For example, IPV is a known consistent and strong risk factor for unintended pregnancy and abortion across a variety of settings.[110] It is important to ask questions particularly for minors or vulnerable women. Minors being sexually abused will be missed if the age of the father is not inquired about. Nearly all the major reports on sexual predators in Rochdale, Oxford, etc implicate doctors and abortionists for not asking the questions they should. We are concerned that this guidance is not balanced, as there is more evidence (from the CQC) that women are likely to be under pressure from abortion providers to proceed with the termination, even if they are ambivalent. There is evidence from CQC Inspections that pressure to have an abortion was common across	termination. However, help making a decision and requiring extra time to make a decision are covered by recommendations 1.1.7 and 1.1.8. It is outside the remit of a NICE guideline to comment on individual CQC findings.

[110] https://www.ncbi.nlm.nih.gov/pubmed/22959631

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				Marie Stopes clinics in the UK where key performance indicators were used and abortions were linked to bonuses.[111] We recommend the following additions to the guidance: • **Any anxiety from pressure to proceed with the termination from providers or others, or any anxiety or ambivalence in her decision** • **Any evidence of possible coercion**	
Christian Medical Fellowship	Guidance	6	21	**1.1.18 Services should be sensitive to the concerns women have about their privacy and confidentiality, including their concerns that information about the termination of pregnancy will be shared with healthcare professionals not directly involved in their care.** RSOP 3 states: *'It is recommended that, wherever possible, the woman's GP should be informed about any treatment for abortion. Then, in the event of a woman requiring post-abortion emergency care or related care in the longer term, the GP would be aware of all treatments provided and be in a better position to determine the*	Thank you for your comment. The evidence showed that women have concerns about the privacy and confidentiality of abortion services and reactions and judgements from others; therefore, the committee made recommendations to reflect this. However, the committee agree that sometimes there may be a compelling need to share information if it is in the woman's best interest; this is discussed in evidence report A. It is basic clinical practice for healthcare professionals to be alert to physical or emotional abuse or coercion and therefore no specific recommendations were made on this point as this is covered by professional guidance (e.g., the

[111] MSI "staff were concerned that 'Did Not Proceed', the term used when women decided not to proceed with treatment, was measured as a KPI [key performance indicator] and linked to their performance bonus. They felt that this encouraged staff to ensure that patients underwent procedures." Staff were concerned that this created "a culture that worked against patient choice," said the report. "One staff member described it as 'feeling like a hamster in a wheel' and said the word, 'Cattle market' came up quite a lot. https://www.dailymail.co.uk/news/article-4998810/Britain-s-largest-abortion-clinic-paid-staff-bonuses.html?login&base_fe_url=http%3A%2F%2Fdailymail.co.uk%2F&validation_fe_uri=%2Fregistration%2Fp%2Fapi%2Ffield%2Fvalidation%2F&check_user_fe_uri=registration%2Fp%2Fapi%2Fuser%2Fuser_check%2F&isMobile=false#newcomment

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				appropriate therapy. All women should be told of their right to confidentiality and their decision must be respected if they do not want their GP to be informed.' Providers should also be aware of concerns with possible coercion or abuse when confidentiality is requested. IPV is a consistent and strong risk factor for unintended pregnancy and abortion across a variety of settings.[112] Note our comments above (comment 12) about confidentiality and self-referral and phone calls The following guidance should be included, from RSOP 3: • **Wherever possible, the woman's GP should be informed about any treatment for abortion so that in the event of a woman requiring post-abortion emergency care or related care in the longer term, the GP would be aware of all treatments provided and be in a better position to determine the appropriate therapy.**	General Medical Council guidance https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent). The introductory text of the guideline has been amended to make reference to this.
Christian Medical Fellowship	Guidance	7	2	**1.2.1 Reassure women that having a termination of pregnancy does not increase their risk of long-term health problems (such as infertility, cancer or mental health issues).** Providing information about the long-term effects of abortion services is part of informed decision-	Thank you for your comment. The guidance makes recommendations relating to the request for an abortion but the guideline scope does not cover how the woman makes that decision as this is covered by legislation and professional guidance. Further, the alternative options to

[112] https://www.ncbi.nlm.nih.gov/pubmed/22959631

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				making. Women should be told this before they decide whether to proceed with their pregnancy or not otherwise their consent cannot be informed. Thus this guidance is outside the narrow entrance point set by NICE of 'requesting termination of pregnancy'. If this information is provided before the termination, then women must be told of other options and pathways prior to the decision. This guidance will be challenging in practice because it is incorrect and does not comply with the law. **Following the Montgomery v Lanarkshire Health Board ruling, [113] [114] doctors must spell out any (even tiny) material risks and any reasonable alternatives in dialogue with patients.** The evidence for long-term mental health effects of abortion on women is controversial but what cannot be ignored or dismissed is the largest, most comprehensive and systematic review (by the Academy of Medical Royal Colleges, funded by the Department of Health in 2011) into the mental health outcomes of induced abortion.[115] This found that women with mental health	abortion are outside the scope of this guideline. The 'this guideline covers' section has been amended to clarify the scope of this guideline and the introductory text has been amended to refer to the Abortion Act and the Department of Health Required Standard Operating Procedures, which provide additional guidance relevant to helping women make a decision. A note has been added to the beginning of the document to remind healthcare professionals of their duty to ensure they are adhering to all applicable requirements The committee agree that it is necessary to fully inform women of risk associated with having an abortion but have not made exhaustive recommendations about this as it is part of good clinical practice. The introductory text has been amended to remind healthcare professionals to provide information and obtain informed consent in line with General Medical Council (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent) guidance and the 2015 Montgomery ruling. The committee were aware that the Academy of Medical Royal Colleges guidance showed that following an unwanted pregnancy, there was not

[113] https://www.supremecourt.uk/cases/docs/uksc-2013-0136-judgment.pdf

[114] Montgomery v Lanarkshire Health Board UKSC 11. 2015.

[115] Induced Abortion and Mental Health: A systematic review of the evidence — full report and consultation table with responses. Academy of Medical Royal Colleges (AoMRC). December 2011

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				problems before an abortion were at **greater risk** of mental health problems post abortion. It also concluded that other factors may be associated with **increased rates of post-abortion mental health problems**, such as a woman having a negative attitude towards abortions in general, being under pressure from her partner to have an abortion or experiencing other stressful life events. These factors together will affect significant numbers of women. '*The most reliable predictor of post-abortion mental health problems is having a history of mental health problems prior to the abortion. A range of other factors produced more mixed results, although there is some suggestion that stressful life events, pressure from a partner to have an abortion, and negative attitudes towards abortions in general and towards a woman's personal experience of the abortion, may have a negative impact on mental health*.[116] The AMRC evidence also concluded that the rates of mental health problems for women with an unwanted pregnancy were **the same**, whether they had an abortion or gave birth. Therefore, when a woman has an unwanted pregnancy, rates of mental health problems will be largely unaffected whether she has an abortion or goes on to give birth. Furthermore, it found that abortion	an increased risk of having mental health problems in women who had an abortion compared with those who have birth. The Ferguson review cited did not control for pre-existing mental health problems, which are more likely to occur again irrespective of whether a woman has an abortion. Further, the Ferguson review acknowledges that comparing women with an unwanted pregnancy that had an abortion with women with an unwanted pregnancy that decided to continue to term may not be the appropriate comparison. They said a more appropriate comparison may be to compare against women with an unwanted pregnancy who were refused an abortion. They were only aware of one study that did this (Gilchrist 1995), but this study showed a higher rate of psychotic illness in women refused an abortion. The language in recommendation 1.2.1 has been amended to just mention infertility, breast cancer and mental health problems, not all long-term health risks. These specific complications were selected because they are covered in the RCOG guidelines, the committee agreed these are those that most commonly cause distress to women and for which the best available evidence shows that there is no increased risk (see evidence report B), although the evidence for these risks was not formally reviewed as part of this guideline. The

[116] National Collaborating Centre for Mental Health. Induced Abortion and Mental Health. London: Academy of Medical Royal Colleges; 2011.bit.ly/2aOxGgZ

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				was associated with a moderate **increase** in the risk of suicidal behaviour.[117] The results of the AMRC review were re-examined by Fergusson, who confirmed that there is no evidence that abortion reduces the mental health risks of unwanted pregnancy. He found that there were small to moderate increases in risks of some mental health problems post abortion.[118] Even the evidence in the NICE reviews (0 and A) cite some of the known risks of abortion as does the NHS website on abortion. **Also, there is strong evidence of a link between abortion and subsequent preterm birth.** The risk of a preterm birth in someone who has had a previous abortion is small but real. In 2013 a review of induced abortion and early preterm birth found *'...a significant increase in the risk of preterm delivery in women with a history of previous induced abortion*.' [119] Women who had one prior induced abortion were 45% more likely to have premature births by 32 weeks, 71% more likely to have premature births by 28 weeks, and more than twice as likely (117%) to have premature births by 26 weeks.	committee acknowledge that there may be some evidence (although this was not reviewed as part of this guideline) of an association between abortion and risk of subsequent pre-term birth but agreed that the evidence for this is less definitive than for the risks discussed above and so did not make recommendations.

[117] (AOR 1.69, 95% CI 1.12-2.54; p<0.01). Fergusson DM et al. Does Abortion reduce the mental health risks of unwanted or unintended pregnancy? A reappraisal of the evidence. *ANZJP* 4 April 2013. DOI: 10.1177/0004867413484579.

[118] Fergusson D, Horwood L & Boden J. Does abortion reduce the mental health risks of unwanted or unintended pregnancy? A re-appraisal of the evidence. *Aust N Z J Psychiatry* 2013;47:1204-1205 *bit.ly/W5FPm5*

[119] Hardy G, Benjamin A, Abenhaim H. Effect of induced abortions on early preterm births and adverse perinatal outcomes. *J Obstet Gynaecol Can* 2013;35(2):138-143 *bit.ly/1nsj5UU*

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				Another research study in 2013 in Finland found a 28% higher risk of an extremely preterm birth.[120] A review published in the *American Journal of Obstetrics & Gynecology* in 2010, found that terminations in the first and second trimesters are associated with a '*very small but apparently real increase in the risk of subsequent spontaneous preterm birth*'. [121] The link is supported by two European studies from 2005 [122] and 2004 [123] and a further two studies from 2009 by Swingle and Shah. Swingle et al. found a 64% increased risk of preterm birth at less than 32 weeks with just a single abortion.[124] Shah et al. found an increased risk of preterm birth of 35% in patients with only one abortion. The risk increased as the number of abortions increased. [125] There are now over 100 studies in the medical literature confirming this association. **In the context of the Montgomery ruling, these known risks must be stated clearly to all women.** • **Inform women of the risk of abortion to their mental health if they have a pre-existing mental health difficulty,**	

[120] Räisänen S, Gissler M, Saari J, Kramer M, Heinonen S. Contribution of risk factors to extremely, very and moderately preterm births — register-based analysis of 1,390,742 singleton births. *PLoS One*. 2013;8(4):e60660 *1.usa.gov/1ClLhmd*

[121] Iams J, Berghella V. Care for women with prior preterm birth. *American Journal of Obstetrics & Gynecology* 2010;203(3):89-100 *1.usa.gov/Y7WEib*

[122] Moreau C et al. Previous induced abortions and the risk of very preterm delivery: Results of the EPIPAGE study. *Br J Obstet Gynaecol* 2005;112:430-437 *1.usa.gov/1A1nvlh*

[123] Ancel P et al. History of induced abortion as a risk factor for preterm birth in European countries: Results of the EUROPOP survey. *Hum Reprod* 2004;19:734-40 *1.usa.gov/1nskDhS*

[124] Swingle H, Colaizy T, Zimmerman M & Morris F. Abortion and the risk of subsequent preterm birth: An asystematic review with meta-analyses. *J Reproductive Med* 2009;54(2):95-108 *1.usa.gov/1qWMU0Q*

[125] Shah P, Zao J. Induced termination of pregnancy and low birth weight and preterm birth: A systematic review and meta-analysis. *BJOG* 2009;16(11):1425-1442 *1.usa.gov/1tWgfxm*

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				ambivalence, stressful life events or any pressure from others to have an abortion • **Inform women of the risk of a pre-term birth in future pregnancies** • **Inform women of the small risk to their future fertility** • **Reassure women that they can opt out at any point and continue with their pregnancy**	
Christian Medical Fellowship	Guidance	7	5, 10-12	**1.2.2 Provide information about the benefits and risks of medical and surgical termination of pregnancy (see table 1). Do this without being directive, so that women can make their own choice.** Evidence shows that complications from medical abortions are **common**, not rare according to official CIOMS criteria.[126] NICE's own evidence states that the effectiveness and safety of the two methods is not similar: '*There was a higher clinically important rate of incomplete termination needing additional surgical intervention for women who had medical termination*.' (p36) In the UK we have poor data collection, so complications are often not linked to abortion, but in countries where data collection on abortions is	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA does not include the wording you refer to. All healthcare professionals providing abortion services must work within the constraints of the law. A reference to the Abortion Act, Department of Health Required Standard Operating Procedures, and other relevant legislation and guidance, has been added to the introductory text and a note has been added to the beginning of the document to remind healthcare professionals of their duty to ensure they are adhering to all applicable requirements. Therefore, where mifepristone is taken was not included in the recommendations as this is covered by legislation. However, the recommendations have been amended to clarify that women up to 9+6 weeks gestation can take the misoprostol at home (or in clinic/hospital) and expel the pregnancy at home

[126] https://www.who.int/medicines/areas/quality_safety/safety_efficacy/trainingcourses/definitions.pdf

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				better, we know that complications after medical abortion higher than after surgical abortion. The largest and most accurate study of medical abortions, a Finnish study of 42,600 women, found that women had **four times as many serious complications** after first trimester **medical abortions than surgical** abortions: 20% compared to 5.6%.[127] Another Finnish study of 24,000 women who had a medical abortion found that 15.4% were later diagnosed with bleeding, 2% had an infection, 10.2% an incomplete abortion, and 13% had to proceed with a vacuum curettage.[128] A recent study in Sweden collected data from nearly 5,000 abortions. Between 2008 and 2015 the rate of complications for medical abortions under 12 weeks' gestation doubled − increasing from 4.2% to 8.2%. Complications from surgical abortions were 5.2%. Moreover, of medical abortions: '*The complication frequency was significantly higher among women < 7 gestational weeks who had their abortions at home*.' (7.3% compared to 2.4% at hospital). The authors also note that the rate of complications is probably an underestimate.[129]	but women at 10+0 will have to take the misoprostol in clinic before expelling the pregnancy at home.

[127] Niinimaki M et al. Immediate complications after medical compared with surgical termination of pregnancy. *Obstetrics and Gynecology* October 2009;114(4):795-804 https://bit.ly/2DJcrIc
[128] Niinimaki M, Suhonen S et al. Comparison of rates of adverse events in adolescent and adult women undergoing medical abortion: population register based study. *BMJ* 20 April 2011. https://bit.ly/2DqZOFB
[129] **Because some women did not report to the clinic within the 30-day follow-up, others may have sought help elsewhere and a number of failed medical abortions were excluded from the study.** Carlsson I et al. Complications related to induced abortion: a combined retrospective and longitudinal follow-up study. *BMC Women's Health* 25 September 2018. https://bit.ly/2DFbrJI

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				Several other studies published in the last ten years show similar differences, with the rate of necessary surgery after an early medical abortion ranging from 3.5% to 7.9% and up to 33% for later abortions.[130] **Therefore, around one out of every 20 women obtaining an early medical abortion will need surgery for haemorrhaging or to remove fetal remains left inside the uterus.** Even for early medical abortions, up to 9 weeks gestation, the RCOG reports (p41) a Finnish study that found 6% of women needed subsequent surgical intervention compared with less than 1% of those having surgical abortions.[131] Part of the reason for this is that high doses of the abortion drugs can lead to unacceptably high levels of side effects, but with lower doses some failures will occur and then abortion by another method is needed. Research by pro-abortion authors has found that for women over seven weeks the failure rate can be up to 33%.[132]	

[130] Mulligan E, Messenger H. Mifepristone in South Australia: The first 1343 tablets. *Australian Family Physician* May 2011; 40(5) https://bit.ly/2Pw6hpC ; Winikoff B et al. Two distinct oral routes of misoprostol in mifepristone medical abortion: a randomized controlled trial. *Obstetrics and Gynecology* December 2008;112(6):1303-10 https://bit.ly/2zXJW9W ; Raymond EG et al. First-trimester medical abortion with mifepristone 200 mg and misoprostol: a systematic review. *Contraception* 2013; 87:26-37 https://bit.ly/2S10BRF

[131] https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf

[132] https://www.ncbi.nlm.nih.gov/pubmed/17707719

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				For medical abortions after 13 weeks, subsequent surgical evacuation rates vary widely between studies, but in one **UK multicentre study** reported by the RCOG (p42), it reached up to **53%.** [133] Medication guides for these pills warn they may cause a number of very serious side effects and they are only available in the USA through a restricted medical program (REMS) and only in certain healthcare settings.[134] Since the deaths of at least 22 women in the USA from taking mifepristone, plus several cases of severe infection and at least 1445 cases with adverse effects since 2012 (289 per year),[135] the FDA has updated its guidance on mifepristone.[136] The medication guide warns that it can cause several serious side effects.[137] Mifepristone is only available in the USA through a restricted medical program (REMS) and only in certain healthcare settings.[138] There is limited data on the outcomes of self-administering abortion pills (to either conclusively prove it is safe or not) but one peer reviewed	

[133] https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf

[134]

[135] FDA. Mifepristone U.S. Post-Marketing Adverse Events Summary through 12/31/2017. https://bit.ly/2Pz0MH6

[136] **US Food and Drug Administration. *Questions and Answers on Mifeprex*. 28 March 2018 https://bit.ly/2yrBtMt**

[137] FDA. Highlights of prescribing information (mifepristone) revised March 2016. https://bit.ly/2Q33bZK

[138] Specifically, clinics, medical offices and hospitals, by or under the supervision of a certified prescriber. It is not available in retail pharmacies and it is not legally available over the Internet. US Food and Drug Administration. *Art cit* https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf

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				study found that **78%** of participants had excessive bleeding, 13% had severe anaemia and 5% shock. 63% had incomplete abortion and 23% had failed abortion. They also found that surgical evacuation had to be performed in 68% of the patients, 13% with a blood transfusion. The authors' conclusion? *'Unsupervised medical abortion can lead to increased maternal morbidity and mortality*.' [139] The RCOG reports that women are more likely to seek medical help for bleeding after medical abortion than after surgical, and to report heavier bleeding than they expected, and for longer. The incidence of haemorrhage is much higher in women undergoing medical abortion, (although there are discrepancies in reported rates due to ill-defined criteria in reporting). The Finnish record-linkage study of 42,600 women found rates of consultation for haemorrhage were 15.6% after medical compared to 2.1% after surgical abortion.[140] Hospitalisation rates, while low overall - but data linkage with abortion is very poor - are worse for medical abortions. Government statistics for England and Wales show complications involving	

[139] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4347129/pdf/jcdr-9-QC01.pdf
[140] https://www.ncbi.nlm.nih.gov/pubmed/19888037

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				hospitalisation are more than twice as likely after medical abortions than after surgical ones: 206 compared to 88.[141] However the RCOG acknowledges that a lack of standardisation in reporting in the UK hampers collection of accurate data **so this number is likely to be higher.** Statistics are usually drawn from clinic or hospital records that will under-represent the true rate as some women experiencing complications follow up elsewhere. NICE currently states that *'The effectiveness and safety of both methods is similar'.* **This statement is incorrect and should be removed.** **Add in guidance to ensure women are informed of the elevated risk of complications from medical termination compared to surgical, specifically the risk of haemorrhaging, infection and incomplete or failed medical abortion.** We recommend noting in the guidance that Government guidelines permit *misoprostol* to be taken at home only up to 9 week + 6 days gestation when *mifepristone* is taken in a clinic, and explaining to women that *mifepristone* must be taken at an approved hospital or clinic.[142]	

[141] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/679028/Abortions_stats_England_Wales_2016.pdf

[142] Approval of home use for the second stage of early medical abortion, Dec 2018
https://www.rcog.org.uk/globalassets/documents/guidelines/early-medical-abortion-at-home-guideline-england.pdf

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Christian Medical Fellowship	Guidance	11	2	**1.2.3 As early as possible, provide women with detailed information to help them prepare for the termination of pregnancy.** As noted in our general comment above, even after the entrance point to the guidance, it cannot be assumed that the decision is final. NICE guidance must correlate with RSOP 14 which says: "*All women requesting an abortion should be offered the opportunity to discuss their options and choices with, and receive therapeutic support from, a trained pregnancy counsellor and* ***this offer should be repeated at every stage of the care pathway.***" • **Inform women that the procedure can be postponed or cancelled and that she remains free to continue with the pregnancy, if she so wishes.**	Thank you for your comment. A reference to the Department of Health Required Standard Operating Procedures, and other relevant legislation and guidance, has been included in the introductory text and a note has been added to the beginning of the document to remind healthcare professionals of their duty to ensure they are adhering to all applicable requirements. Recommendation 1.1.8 has been amended to say women should be provided with, or referred to support to make a decision if they request this, in line with yours and others' comments.
Christian Medical Fellowship	Guidance	11	6	**1.2.4 Provide information in a range of formats, for example video or written information. Include information based on the experiences of women who have had a termination of pregnancy.** • **Include a range of experiences such as those with prior and post mental health problems, those who have been hospitalised, who have experienced other complications with their termination, and those who have had a subsequent pre-term birth, in order to**	Thank you for your comment, the recommendation states that information should be based on women's experiences, without specifying whether they should be positive or negative. The range of experiences will greatly differ between women and therefore the committee agreed that it would not be helpful to add a list which could not be exhaustive. Detail about the language of information was not included in the recommendations as this is covered in the NICE guideline on patient experience in adult NHS services that is referred to in recommendation 1.2.5

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				fairly reflect the true breadth of experiences • **Include information in different languages**	
Christian Medical Fellowship	Guidance	12	5	**1.2.6 Ask women if they want information on contraception, and if so provide information about the options available to them.** • **Ask women if they want information on contraception, and if so provide information about the options available to them, including effectiveness of different types.**	Thank you for your comment. It was not possible to make recommendations about the effectiveness of different methods of contraception as this evidence was not reviewed as part of this guideline. The committee are aware of guidance from the Faculty of Sexual and Reproductive Healthcare about contraception use after pregnancy. This information has been added to the discussion in evidence report B.
Christian Medical Fellowship	Guidance	12	7	**1.2.7 For women who are having a medical termination of pregnancy, explain:** • **that they may see the pregnancy as they pass it** • **what the pregnancy will look like** • **whether there may be any movement.** If a woman is not told that it is a small fetus or baby that she is 'passing' she will be more adversely affected than if she is warned that she will be passing recognisable human parts, particularly for later terminations. We are concerned about the use of language in this guidance. The word fetus should be used, not pregnancy, for consistency and medical accuracy. NICE Evidence clearly warns of the problems with lack of accuracy and information provision: *"women were not given enough information to prepare them for the abortion, which is a*	Thank you for your comment. The guideline refers to various gestations in the recommendations, and it would not be clinically accurate to refer to the pregnancy at some of these points as a fetus. Therefore, the decision was taken by the committee to use the term 'pregnancy' throughout the recommendations for accuracy and consistency. Recommendation 1.2.7 states that healthcare professionals should inform women about what they should expect to see and what the pregnancy may look like when she passes it. This will differ depending on the gestation and therefore the committee agreed that this recommendation would prompt healthcare professionals to use their clinical judgement to give women the relevant information for their gestation. The language in evidence report B has

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				responsibility of the caregivers: "I was not prepared for the "little human being" about 12 in." [143] [144] Another study described how "*The picture of the fetus was something they would never forget. "You could see fetus, where the ears were, the arms, I was really frightened."*[145] Amend the guidance: • **that they may see recognisable human parts as they pass it** • **what the human parts may look like**	been amended to be consistent with the recommendations.
Christian Medical Fellowship	Guidance	12	19	**1.2.11 If termination of pregnancy for fetal anomaly cannot be provided in the maternity setting, establish a clear referral pathway with ongoing communication between services so that women can:** • **easily transfer to the termination service** • **get more information about the anomaly** In one British study, when parents were offered perinatal hospice as an option, 40% chose to continue with their pregnancies.[146] The comparative figure in US studies was between 75% and 85%.[147] Amend the guidance:	Thank you for your comment. The guideline is for people who have requested an abortion and covers safe and effective abortion care. The alternative options to abortion are outside the scope of this guideline. Information about the nature of a fetal anomaly would normally be provided by the maternity service or fetal medicine specialist that diagnosed the fetal anomaly. Women have the right to change their mind and clinicians should follow professional guidance (e.g., the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent). If a woman decides she does not wish to have an abortion

[143] Evidence Review B, p. 42
[144] Evidence Review B, p. 69
[145] Evidence Review B, p. 69
[146] Arch Dis Child FetalNeonatal Ed. 2007 Jan;92(1):F56-8. Breeze AC et al. Palliative care for prenatally diagnosed lethal fetal abnormality.
[147] http://www.aaplog.org/wp-content/uploads/2015/07/AAPLOG-Practice-Bulletin-1.compressed.pdf

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				• **Provide more information about the anomaly from parents who have a child with the anomaly or from written resources provided by specialists** • **inform women that they can change their minds at any point and can access support services for continuing the pregnancy, palliative care, perinatal hospices and specialist disability groups** • **Be informed of the likelihood of the diagnosis being correct or incorrect** • **Ensure women can change their minds at any point in the process** **Access specialist counselling at any stage in the process**	she will no longer be cared for by that service, and therefore falls outside the scope of this guideline. Access to support with making a decision and counselling after an abortion are covered by recommendations 1.1.8 and 1.14.6.
Christian Medical Fellowship	Guidance	12	24	**1.2.12 Explain to women that the fetus may not look abnormal despite there being a fetal anomaly.** A British Parliamentary Inquiry into abortion on the grounds of disability concluded that: '*...the studies have all found that around 20% of women, between one and two years after an abortion for fetal abnormality, have a psychiatric condition, usually a complicated grief reaction, a depressive disorder or post-traumatic stress disorder.*'[3] **Warning of possible long-term mental health outcomes should be included in guidelines**	Thank you for your comment. The committee agreed that there was no robust evidence that mental health problems after an abortion for fetal anomaly are a result of having an abortion, rather than the fetal anomaly. However, the committee agreed that some women may need support after an abortion which is covered by recommendations 1.14.3 to 1.14.6.
Christian Medical Fellowship	Guidance	15	5	**1.6.1 Offer a choice between medical or surgical termination of pregnancy before 24+0 weeks' gestation (see table 1). If any methods**	Thank you for your comment. According to the evidence review (see Evidence report K) serious complications are rare after either type of procedure. There was also evidence that women

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				would not be clinically appropriate, explain why. Complications from medical abortions are **common**, not rare according to official CIOMS criteria.[148] See comments at 21 above for comparative safety of medical and surgical abortions. The evidence review states that (Page 36 lines 27 to 29) '*There was a higher clinically important rate of incomplete termination needing additional surgical intervention for women who had medical termination'*. • **Inform women of the higher risk of complications from later medical abortions (serious complications for 1 in 5 women after the first trimester[149])** • **Inform women that medical abortions between 10 and 24 weeks will require subsequent surgery to completely empty the womb in 13% of cases[150]** • **Consider if medical abortion, unsupervised, is appropriate or in the best interests of young or vulnerable women.** Where adequate safety and support system resources are limited, for example for those living	want a choice of abortion method (see evidence report B). Therefore, the committee agreed a choice should be offered. This decision point should be accompanied with recommendation 1.2.2, in terms of information provided at the time, as well as the Patient Decision Aid that accompanies the guideline. As with the other recommendations and NICE guidelines, this is guidance only and does not override clinical judgement. Therefore, it is up to the clinician to assess whether recommendations are appropriate for a given patient.

[148] https://www.who.int/medicines/areas/quality_safety/safety_efficacy/trainingcourses/definitions.pdf
[149] Niinimaki M et al. Immediate complications after medical compared with surgical termination of pregnancy. *Obstetrics and Gynecology* October 2009;114(4):795-804 https://bit.ly/2DJcrlc
[150] Niinimaki M, Suhonen S et al. Comparison of rates of adverse events in adolescent and adult women undergoing medical abortion: population register based study. *BMJ* 20 April 2011. https://bit.ly/2DqZOFB

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				in remote areas, home-based abortions should not be offered. Surgical abortion is an option for those who cannot get home before bleeding begins, including those who cannot access medical services quickly after the abortion. **Where women have transport problems, medical abortion is contra-indicated and surgical abortion should be provided instead.**	
Christian Medical Fellowship	Guidance Evidence Review F	15 11	10 14-52	**1.7.1 Consider termination of pregnancy before there is definitive ultrasound evidence of an intrauterine pregnancy (a yolk sac) for women who do not have signs or symptoms of an ectopic pregnancy.** We are concerned that this recommendation is based on speeding up the process towards termination, over-riding the prioritising of safety concerns from a possible ectopic pregnancy. There is no clear evidence provided that women would prefer to access abortion so quickly that they are prepared to risk their own health and future fertility. Evidence shows that women overwhelmingly support waiting periods between an initial consultation and an abortion taking place – 79% agree compared to 9% who disagree with this.[151] **Women's safety and health must always override timeliness (CF RSOP 11)** **We recommend that this guidance be removed.**	Thank you for your comment. The evidence review (see evidence report F) did not show any increased risks associated with performing an abortion before definitive ultrasound evidence. Publicly available pregnancy tests can accurately detect a pregnancy at very early gestations, weeks before the pregnancy is visible on ultrasound. Therefore, once a women has requested an abortion she should not be faced with unnecessary delays due to services requiring ultrasound confirmation. This recommendation is consistent with guidance from the Royal College of Obstetricians and Gynaecologists (which states routine ultrasound scanning is unnecessary). However, the committee discussed the risk of a missed ectopic pregnancy and reflected this in the strength of recommendation 1.7.1 and the inclusion of recommendation 1.7.2.

[151] https://www.comresglobal.com/wp-content/uploads/2017/05/Where-Do-They-Stand-Abortion-Survey-Data-Tables.pdf

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Christian Medical Fellowship	Guidance	15	13	**1.7.2 For women who are having a termination of pregnancy before there is definitive ultrasound evidence of an intrauterine pregnancy (a yolk sac):** **We recommend this guidance be removed (see comment 29 above).** If is it retained then strengthen the following guidance: • **explain that women must have follow-up appointments with subsequent ultrasound to ensure the pregnancy has been terminated and to monitor for ectopic pregnancy**	Thank you for your comment. The evidence review (see evidence report F) did not show any increased risks associated with performing an abortion before definitive ultrasound evidence. However, the wording of the recommendation reflects the fact that the evidence was not of a sufficient quality to make a strong recommendation. This recommendation is consistent with guidance from the Royal College of Obstetricians and Gynaecologists (which states routine ultrasound scanning is unnecessary). Recommendation 1.7.2 refers to the potential need for follow-up, which would be applicable when the success of an abortion cannot immediately be ascertained. Women who had had a very early surgical abortion where the success of the abortion can be ascertained straightaway through the inspection of chorionic villi would not need any follow-up, for example. Recommendations 1.14.1 and 1.14.2 cover follow-up of women who have early medical termination, outlining that a pregnancy test should be provided to exclude ongoing pregnancy. Having included recommendation 1.7.2 and 1.14.1-2 to minimise the risk of an undiagnosed ectopic pregnancy, the committee agreed that recommendation 1.7.1 will reduce unnecessary delays due to services requiring ultrasound confirmation and result in safer abortion care as the risks of abortion increase with increasing gestations (see evidence report A).

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Christian Medical Fellowship	Guidance	16	5	**1.8.1 Offer the option of expulsion at home to women who are having a medical termination of pregnancy if they will be taking the mifepristone before 10+1 weeks' gestation.** Complications from medical abortions are **common**, not rare according to official CIOMS criteria.[152] A recent study in Sweden collected data from nearly 5,000 abortions. Between 2008 and 2015 the rate of complications for medical abortions under 12 weeks' gestation doubled − increasing from 4.2% to 8.2%. Complications from surgical abortions were 5.2%. Of early medical abortions at home: '*The complication frequency was significantly higher among women < 7 gestational weeks who had their abortions at home*.' (7.3% compared to 2.4% at hospital). The authors also note that the rate of complications is probably an underestimate.[153] There is limited data on the outcomes of self-administering abortion pills but one peer reviewed study found that 78% of participants had excessive bleeding, 13% had severe anaemia and 5% shock. **63% had an incomplete abortion and 23% had a failed abortion**. They also found that surgical evacuation had to be performed in 68% of the	Thank you for your comment. The evidence reviewed for this question (see evidence report G) did not show increased complication rates in the '9+1 to 12+0 weeks' gestation' group relative to the '<9+1 weeks' gestation' group who both had home expulsion, with the exception of a higher rate of vomiting in the former. The evidence comparing rate of complications for home expulsion compared with in hospital was not reviewed as part of this guideline. However, the study you reference (Carlson 2018) did not show a significant difference in complication rates between groups (RR 2.99, 95% CI 0.42–21.4 for women < 7 gestational weeks who had their abortions at home; and RR 1.30, 95% 0.57–2.97 for the whole cohort). Gestational age should be checked as part of normal clinical practice and would form part of the assessment. As with the other recommendations and NICE guidelines, this is guidance only and does not override clinical judgement. Therefore, it is up to the clinician to assess whether recommendations are appropriate for a given patient.

[152] https://www.who.int/medicines/areas/quality_safety/safety_efficacy/trainingcourses/definitions.pdf

[153] Because some women did not report to the clinic within the 30-day follow-up, others may have sought help elsewhere and a number of failed medical abortions were excluded from the study. Carlsson I et al. Complications related to induced abortion: a combined retrospective and longitudinal follow-up study. *BMC Women's Health* 25 September 2018. https://bit.ly/2DFbrJI

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				patients, 13% with a blood transfusion. The authors concluded that: *'Unsupervised medical abortion can lead to increased maternal morbidity and mortality*.'[154] The second visit to a medical clinic builds in an important safety feature by allowing for direct observation and monitoring of the administration of *misoprostol* at a precise time, method and place after *mifepristone* administration. **The precise time interval** between taking mifepristone and taking misoprostol is critically important in the effectiveness of the regimen and directly affects how likely the woman is to experience a failed drug-induced abortion and require surgery. Yet there is nothing to stop a woman taking this outside the recommended hours if she is outside of medical supervision. One study (by authors who campaign for abortion) found that using *misoprostol* sooner than 24 hours after *mifepristone* leads to a significantly increased failure rate: women under seven weeks gestation had a failure rate of 27% while women between seven and eight weeks gestation had a failure rate of 31%. The authors of this study recommend that buccal misoprostol not be taken immediately after mifepristone because of the high abortion failure	

[154]Nivedita K et al. Is It Safe to Provide Abortion Pills over the Counter? A Study on Outcome Following Self-Medication with Abortion Pills. 2015. https://bit.ly/2B7soKu

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				rate.[155] A further study also concludes that a six-hour gap '*…is not as effective at achieving a complete abortion compared with the 36- to 48-hour protocol*.'[156] When part of the termination process takes place outside medical centres, it removes medical information, supervision and support for what is a medical procedure. While this is of concern for all women it is particularly so with **teenage girls or other vulnerable women.** Women with learning difficulties or co-existing medical or mental health conditions, who may struggle to understand or interpret guideline recommendations for medicines, will also be vulnerable where the trend is towards home-based abortions. It cannot be assumed that all women will follow, understand or even be able to read the directions before taking the powerful drug. There is no legal requirement for a woman to follow medical instructions and there is no monitoring, so there can be little (if any) control over following instructions. Where adequate safety and support system resources are limited, for example for those living in remote areas, home-based abortions should not be offered. In view of the high rates of bleeding and haemorrhaging after medical abortion, there are clear dangers if a woman is unable to reach a	

[155] Lohr PA et al. Oral mifepristone and buccal misoprostol administered simultaneously for abortion: a pilot study. *Contraception* September 2007;76(3):215-20 https://bit.ly/2qP7vxG
[156] Guest et al. Randomised controlled trial comparing the efficacy of same-day administration of mifepristone and misoprostol for termination of pregnancy with the standard 36 to 48 hour protocol. *BJOG* February 2007;114(2):207-15. https://bit.ly/2qLAdzo

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				hospital quickly in an emergency, or if the home has no working telephone (or other basic equipment) in a crisis. We note that the evidence review states that (Page 36 lines 27 to 29) '*There was a higher clinically important rate of incomplete termination needing additional surgical intervention for women who had medical termination*'. • **Inform women that the frequency of complications is higher for women having early medical abortions at home.**[157] • **Ensure that gestational age is correct before offering options**[158] • **Consider if taking *misoprostol* at home is appropriate or in the best interests of young or vulnerable women** • **Where women have transport problems, medical abortion is contra-indicated and surgical abortion should be provided instead**	

[157] **Complications related to induced abortion: a combined retrospective and longitudinal follow-up study. *BMC Women's Health* 25 September 2018.** https://bit.ly/2DFbrJI

[158] One-third of women who were followed up after receiving 'treatment' had pregnancies of ten weeks gestation or more, when checked by ultrasound. Some even had pregnancies of 18-28 weeks, far off the recommended maximum of ten weeks.

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Christian Medical Fellowship	Guidance	16	9	**1.9.1 Offer interval treatment (usually 24 to 48 hours) with mifepristone and misoprostol to women who are having a medical termination of pregnancy between 9+1 and 10+0 weeks' gestation** Research has shown that women have a strong preference for a short time interval between the mifepristone and misoprostol, and consequently may well be inclined to take it quicker.[159] But the use of misoprostol sooner than 24 hours after mifepristone leads to a significantly increased failure rate with one study finding that nearly one out of every three to four women who took buccal misoprostol shortly after mifepristone failed to abort. For women who are *over seven weeks* gestation (when medical abortions are most commonly used) the failure rate was up to 31%.[160] Removing medical supervision over the timing of misoprostol administration, allowing women take it at a time 'convenient for them', will increase failure rates, complications (including infection) and need for subsequent surgery. • **Ensure that gestational age is correct before offering options[161]**	Thank you for your comment. The evidence reviewed for this question did not show increased failure rates after administration of misoprostol less than 24 hours after mifepristone (see evidence report H). However, between 9+1 and 10+0 weeks' gestation" in recommendation 1.9.1 has now been amended to 'up to and including 10+0 weeks gestation' to clarify that interval treatment should be offered to all women having early medical abortion (in addition to offering the option of simultaneous treatment to women up to and including 9+0 weeks' gestation). The recommendation for simultaneous mifepristone and misoprostol also now specifies vaginal misoprostol which is what was used in the evidence reviewed for this question. Gestational age should be checked as part of normal clinical practice and would form part of the assessment. Recommendation 1.9.2 explains the risks associated with taking mifepristone and misoprostol at the same time.

[159] https://www.acog.org/-/media/Practice-Bulletins/Committee-on-Practice-Bulletins----Gynecology/Public/pb143.pdf?dmc=1
[160] https://www.ncbi.nlm.nih.gov/pubmed/17707719
[161] '*…Gestational age assessment before undergoing medical pregnancy termination is necessary to ensure women take the recommended dose and regimen of medications, and in the appropriate setting*' and there are large variances in self-calculated gestational age. https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.14646

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				• **Ensure women are aware of the importance of the interval in treatment**	
Christian Medical Fellowship	Guidance	16	12	**1.9.2 For women who are having a medical termination of pregnancy before 9+1 weeks' gestation, give them the choice of having mifepristone and misoprostol at the same time, but explain that:** **• the risk of ongoing pregnancy may be higher, and it may increase with gestation** **• it may take longer for the bleeding and pain to start** **• it is important for them to complete the same follow-up programme that is recommended for all medical terminations before 10+1 weeks before 9 weeks** Research has found that one-third of women who were followed up after receiving 'treatment' had pregnancies of ten weeks gestation or more, when checked by ultrasound. Some even had pregnancies of 18-28 weeks, far off the recommended maximum of ten weeks.[162] Because of increasing uterine sensitivity to misoprostol with advancing gestational age, regimens for medical termination change in the late first trimester and second trimester to repeated, lower doses of misoprostol. The woman's experience will also be more painful later	Thank you for your comment. The evidence reviewed for this question did not show increased failure rates after administration of misoprostol less than 24 hours after mifepristone (see evidence report H). The studies you cite did not meet the inclusion criteria for the evidence review as they did not compare simultaneous to interval treatment. However, the recommendation for simultaneous mifepristone and misoprostol now specifies vaginal misoprostol which is what was used in the evidence reviewed for this question. Gestational age should be checked as part of normal clinical practice and would form part of the assessment. Both pills will need to be taken in clinic/hospital as per the law, and therefore this does not need to be explicitly stated. A reference to the Abortion Act, and other relevant legislation and guidance, has been included in the introductory text and a note has been added to remind healthcare professionals of their duty to work within the constraints of the law and ensure they are adhering to all applicable requirements.

[162] Ibid

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				in gestation, with an exponentially increasing rate of haemorrhage and complications after just seven weeks gestation. BPAS state that taking both medicines at the same time causes more side effects and is less effective than when they are taken at least one day apart – the recommended protocol.[163] One study (by authors who are pro-abortion) found that for women under 49 days' gestation, the failure rate was 27% if they took the misoprostol immediately after mifepristone.[164] For women between 50-56 days' gestation, the failure rate was 31%. **The authors of this study strongly recommended that buccal misoprostol not be taken immediately after mifepristone because of the high abortion failure rate.** Another study also concluded that a six hour gap '…*is not as effective at achieving a complete abortion compared with the 36- to 48-hour protocol*.'[165] A meta-analysis of 20 studies in 2015 comments on the lack of research and understanding of the effect of taking misoprostol at varying times after mifepristone. It warns of the '*paucity of data on the actual time interval at which women actually administer misoprostol when instructed'.* It adds	

[163] https://www.bpas.org/abortion-care/abortion-treatments/the-abortion-pill/abortion-pill-up-to-10-weeks/
[164] https://www.ncbi.nlm.nih.gov/pubmed/17707719
[165] https://www.ncbi.nlm.nih.gov/pubmed/17305893

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				that: '*Our ability to fully understand if buccal misoprostol is more effective with a dosing interval closer to 48 hours is limited by the relatively small number of women in protocols.*'[166] We recommend noting in the guidance that Government guidelines permit *misoprostol* to be taken at home only up to 9 week + 6 days gestation when *mifepristone* is taken in a clinic.[167] • **Explain that *mifepristone* must be taken at an approved hospital or clinic so *misoprostol* will also need to be taken there** • **Recommend that buccal misoprostol not be taken immediately after mifepristone because of the high failure rate (for 1 in 4 women)** • **Ensure that the gestational age is correct before offering options[168]**	
Christian Medical Fellowship	Guidance	17	2	**1.10.1 For women who are having a medical termination of pregnancy between 10+1 and**	Thank you for your comment. It is part of standard clinical practice to assess the gestational age

[166] https://www.ncbi.nlm.nih.gov/pubmed/26241251

[167] Approval of home use for the second stage of early medical abortion, Dec 2018 https://www.rcog.org.uk/globalassets/documents/guidelines/early-medical-abortion-at-home-guideline-england.pdf

[168] '*…Gestational age assessment before undergoing medical pregnancy termination is necessary to ensure women take the recommended dose and regimen of medications, and in the appropriate setting*' and there are large variances in self-calculated gestational age. https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.14646

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				23+6 weeks' gestation and who have taken 200 mg mifepristone, offer an initial dose (36 to 48 hours after the mifepristone) of: **• 800 micrograms misoprostol, given vaginally, or** **• 600 micrograms of misoprostol, given sublingually, for women who decline vaginal misoprostol.** **Follow the initial dose with 400 microgram doses of misoprostol (vaginal, sublingual or buccal), given every 3 hours until expulsion.** '…*Gestational age assessment before undergoing medical pregnancy termination is necessary to ensure women take the recommended dose and regimen of medications, and in the appropriate setting*' and there are large variances in self-calculated gestational age.[169] One-third of women who were followed up after receiving 'treatment' had pregnancies of ten weeks gestation or more, when checked by ultrasound. Some even had pregnancies of 18-28 weeks, far off the recommended maximum of ten weeks.[170] The later in gestation that medical abortions take place, the less effective and the more dangerous they are. Ten weeks is the maximum gestation	before offering treatment. Recommendation 1.2.2 covers explaining the risks and benefits of different methods of abortion, including the likelihood of needing an additional procedure. This is also included in a patient decision aid that will be published alongside the final guideline.

[169] https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.14646
[170] Ibid

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				recommended. Because of increasing uterine sensitivity to misoprostol with advancing gestational age, regimens for medical termination change in the late first trimester and second trimester to repeated, lower doses of misoprostol. The woman's experience will also be more painful later in gestation, with an exponentially increasing rate of haemorrhage and complications after just seven weeks gestation. • **Ensure that the gestational age is correct before offering options**[171] • **Inform women that medical abortions between 10 and 24 weeks will require subsequent surgery to completely empty the womb in 13% of cases.**[172]	
Christian Medical Fellowship	Guidance	17	10	**1.10.2 Use a shorter interval between mifepristone and misoprostol if the woman prefers this, but explain that it may take a longer time from taking the first misoprostol dose to complete the termination of pregnancy.** See comment 33 above	Thank you for your comment. Where mifepristone is taken was not included in the guideline as it is a legal requirement that this is taken at an approved place. A reference to the Abortion Act, and other relevant legislation and guidance, has been included in the introductory text and a note has been added to remind healthcare professionals of

[171] '*…Gestational age assessment before undergoing medical pregnancy termination is necessary to ensure women take the recommended dose and regimen of medications, and in the appropriate setting*' and there are large variances in self-calculated gestational age. https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.14646

[172] Niinimaki M, Suhonen S et al. Comparison of rates of adverse events in adolescent and adult women undergoing medical abortion: population register based study. *BMJ* 20 April 2011. https://bit.ly/2DqZOFB

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				We recommend noting in the guidance that Government guidelines permit *misoprostol* to be taken at home only up to 9 week + 6 days gestation when *mifepristone* is taken in a clinic, and explaining to women that *mifepristone* must be taken at an approved hospital or clinic.[173] • **Ensure that the gestational age is correct before offering options**[174] • **Recommend that buccal misoprostol not be taken immediately after mifepristone because of the high failure rate (for 1 in 4 women)**	their duty to work within the constraints of the law and ensure they are adhering to all applicable requirements. It is part of standard clinical practice to assess the gestational age before offering treatment. Recommendation 1.10.1 (which should be applied in connection with 1.10.2) recommends using an initial dose of vaginal or sublingual misoprostol after mifepristone. Buccal misoprostol is only recommend as additional doses after the initial dose of vaginal or sublingual misoprostol.
Christian Medical Fellowship	Guidance	18	1	**1.11.3 For women who are having a medical termination of pregnancy after 28+0 weeks' gestation, consider 200 mg oral mifepristone, followed by 100 micrograms misoprostol (vaginal, buccal or sublingual) every 6 hours until delivery.** Amend guidance: **For women who are having a medical termination of pregnancy after 28+0 weeks'**	Thank you for your comment. This was not included as it is a legal requirement. However, the 'why the committee made the recommendations' section outlines the statutory grounds for abortion after 24 weeks. A reference to the Abortion Act, and other relevant legislation and guidance, has been included in the introductory text and a note has been added to remind healthcare professionals of their duty to work within the

[173] Approval of home use for the second stage of early medical abortion, Dec 2018 https://www.rcog.org.uk/globalassets/documents/guidelines/early-medical-abortion-at-home-guideline-england.pdf

[174] '*…Gestational age assessment before undergoing medical pregnancy termination is necessary to ensure women take the recommended dose and regimen of medications, and in the appropriate setting*' and there are large variances in self-calculated gestational age. https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.14646

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				gestation, for serious fetal abnormality or if the life of the mother is at risk, consider….	constraints of the law and ensure they are adhering to all applicable requirements.
Christian Medical Fellowship	Guidance	20	10	**1.14.1 For women who have had a medical termination of pregnancy before 10^{+1} weeks' gestation with expulsion at home, offer the choice of self- assessment, including remote assessment (for example telephone or text messaging), as an alternative to clinic follow-up.** Information about abortion history becomes particularly and critically important when evaluating a woman for infection after abortion and this cannot be done effectively and safely and privately over text messaging. Follow up using mobile phone apps or text messaging is highly irresponsible, since complications from medical abortions are common, not rare, according to official CIOMS criteria.[175] We cite above examples of the high rates of haemorrhage after early medical abortion and the significant numbers of women requiring surgical follow up. Several studies published in the last ten years show the rate of necessary surgery after an early medical abortion ranging from 3.5% to 7.9% and up to 33% for later	Thank you for your comment. The recommendations on follow up are about ensuring the successful completion of the abortion and are based on the evidence provided by 6 RCTs, which all showed that remote follow-up is a safe and acceptable alternative to in-clinic follow-up and that serious complications arising from induced abortions are rare (for detail see Evidence Report I). Complication rates after an abortion, including the need for an additional procedure, are covered by recommendation 1.2.2 and a patient decision aid that will be published alongside the final guideline. Further, remote follow-up using text messaging or phone apps is already used by other services, e.g., chlamydia screening.

[175] https://www.who.int/medicines/areas/quality_safety/safety_efficacy/trainingcourses/definitions.pdf

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				abortions.[176] **Therefore, around one out of every 20 women obtaining an early medical abortion will need surgery for haemorrhaging or to remove fetal remains left inside the uterus.** Abortion pill provider, Women on Web, also found from their own surveys that 12–21% of women subsequently needed a surgical intervention and almost half of women who were over twelve weeks gestation (45%), required a surgical intervention.[177] A recent study in Sweden collected data from nearly 5,000 abortions. Between 2008 and 2015 the rate of complications for medical abortions under 12 weeks' gestation doubled − increasing from 4.2% to 8.2%. Complications from surgical abortions were 5.2%. Moreover, of medical abortions: '*The complication frequency was significantly higher among women < 7 gestational weeks who had their abortions at home*.' (7.3% compared to 2.4% at hospital). The authors also	

[176] Mulligan E, Messenger H. Mifepristone in South Australia: The first 1343 tablets. *Australian Family Physician* May 2011; 40(5) https://bit.ly/2Pw6hpC ; Winikoff B et al. Two distinct oral routes of misoprostol in mifepristone medical abortion: a randomized controlled trial. *Obstetrics and Gynecology* December 2008;112(6):1303-10 https://bit.ly/2zXJW9W ; Raymond EG et al. First-trimester medical abortion with mifepristone 200 mg and misoprostol: a systematic review. *Contraception* 2013; 87:26-37 https://bit.ly/2S10BRF

[177] https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.14646

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				note that the rate of complications is probably an underestimate.[178] • **Inform women that significant numbers of early medical abortions will require subsequent surgery to completely empty the womb** • **Strongly recommend that women follow up with a GP or the abortion provider** • **Remove the reference to text messaging**	
Christian Medical Fellowship	Guidance	20	17	**1.14.3 Explain to women:** **• what aftercare and follow-up to expect** **• what to do if they have any problems after the termination of pregnancy, including how to get help out of hours** **• that it is common to feel a range of emotions after the termination.** **The guidance needs to provide information on the necessary follow up of patients**: what information should be given? How long will support be offered? What guidance is there to ensure a successful procedure?	Thank you for your comment. Follow-up is covered by recommendations 1.14.1 and 1.14.2. Further information about follow-up is included in the Patient Decision Aid accompanying the guideline. The committee agreed that there should be no time limit on when support can be accessed following an abortion, which is explained in the committee discussion in evidence report O. The evidence reviewed showed that remote follow-up is a safe and acceptable alternative to in-clinic follow-up (for detail see Evidence Report I) and, therefore, recommendation 1.14.1 says remote assessment should be offered as an alternative to

[178] Because some women did not report to the clinic within the 30-day follow-up, others may have sought help elsewhere and a number of failed medical abortions were excluded from the study. Carlsson I et al. Complications related to induced abortion: a combined retrospective and longitudinal follow-up study. *BMC Women's Health* 25 September 2018. https://bit.ly/2DFbrJI

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				And what guidance should be provided for patients who do not engage with follow up? Add in the following guidance: • **Recommend routine GP or clinic follow up for all patients to ensure physical and emotional health**	clinic follow-up. However, this does not mean that clinic follow-up cannot also be offered if this considered appropriate.
Christian Medical Fellowship	Guidance	20	22	**1.14. 4 Advise women to seek emotional support if they need it, and how to access it (if relevant). This could include:** • **support from family and friends** **• peer support, or support groups for women who have had a termination of pregnancy** **• counselling or psychological interventions.** • **Information on independent counselling services not linked to the abortion provider**	Thank you for your comment. The committee did not specify where counselling should be provided as some women may prefer to have this within the abortion service to maintain privacy and confidentiality, but others may want independent counselling which has been suggested by other stakeholders. Therefore, the recommendations have been left as 'provide or refer' to give services and women the options of both providing this in house and referring to independent services.
Christian Medical Fellowship	Guidance	21	5	**1.14.4 Providers should offer emotional support after termination of pregnancy, and (if needed) provide or refer women to counselling services.** It is rare that women return to the place where they had the termination, instead preferring to have counselling from independent clinics not associated with the termination. We know from anecdotal data that the psychological fall out from medical abortions completed at home can be severe, partly because women usually see the fetus, which they then	Thank you for your comment. The committee did not specify where counselling should be provided as some women may prefer independent counselling as suggested, but others may prefer to have this within the abortion service to maintain privacy and confidentiality which has been suggested by other stakeholders. Further, in the committee's experience, some women do return to services for support and counselling after having an abortion. Therefore, the recommendations have been left as 'provide or refer' to give services and women the options of both providing this in

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				have to flush away themselves. It is not hidden from them in the way a surgical abortion keeps the fetus from view of the woman. Moreover, the reminder of the abortion is always in the home, not in an anonymous clinic that they can leave behind. **Commissioners must ensure that there is sufficient capacity and resourcing to provide counselling services for women following terminations** • **Providers should offer information on independent counselling services.** • **In cases of abortion for fetal anomaly, providers should offer or refer to bereavement midwife support**	house and referring to independent services. There was insufficient evidence to support recommending the involvement of bereavement midwives. However, this would normally be arranged through the fetal medicine department, not the abortion service.
Church of England: (MPAC)	Guideline	General	General	The 1967 Abortion Act (and subsequent legislation) sought to address the distinct though related issues of women's reproductive health, the interests of embryos and foetuses, conscientious objections of healthcare professionals and societal opinion. In these draft guidelines, women's reproductive health issues have been addressed in a way that marginalises the other areas of interest. In particular, the guidelines present termination of pregnancy as a relatively routine health procedure akin to any other. The fact that abortion is the subject of primary legislation demonstrates that this is not the case. Societal debate on the ethical implications of abortion is also still widespread. In our comments below, we seek to highlight areas where we believe the guidelines ought to be amended in order to reflect	Thank you for your comments. The Department of Health and Social Care asked NICE to develop a guideline on abortion care. The purpose of this guideline, and improving access to services, is to ensure that abortions are conducted under the safest circumstances possible.

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				the importance of issues complementary to women's reproductive health. We do this without prejudice to the Church of England's stated view on abortion which combines principled opposition to abortion in all but limited circumstances with a strong commitment to ensuring the best possible medical, pastoral and spiritual care for all women regardless of the decisions they might make with regard to their own pregnancies.	
Church of England: (MPAC)	Guideline	4	9	We are concerned that by removing referral by GPs from the care pathway, an important step in care, *particularly of vulnerable women*, is eliminated. Providers of services are unlikely to have background information on the physical, social and mental health of women who self-refer and, given the nature of the service they provide, are less likely than GPs to discuss comprehensive options for women who are pregnant and who are considering, but not certain that termination is their preferred pathway.	Thank you for your comment. The evidence identified in our review indicates that self-referral improves access & should result in abortions taking place at early gestations, and therefore with less complications. Our evidence review found that women want improved access and better information provision. It is part of basic clinical care for healthcare professionals to ensure that women are not under physical or emotional duress and would form part of the assessment. Recommendation 1.1.8 has been amended to say women should be provided with, or referred to support to make a decision if they request this, in response to yours and others' comments.
Church of England: (MPAC)	Guideline	4	11	Health professionals' right to conscientious objection also needs to be respected and protected. We recommend that this sentence should read 'Without prejudice to their right to conscientious objection, health professionals…..'	Thank you for your comment. The committee did not think this recommendation needed expanding as it is consistent with professional guidance (e.g., the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice) and it is not the focus of this guideline to provide further guidance on this. However, the rationale

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					section has been expanded to make it clear that healthcare professionals have a right to their personal beliefs and to opt out of performing a procedure, but cannot opt out of providing access.
Church of England: (MPAC)	Guideline	5	4	While counselling might not be compulsory, it is important that every woman is offered impartial counselling, preferably by a counsellor not employed by the providing body to avoid any potential conflict of interest. The Guideline should specifically state that providers **must** offer women counselling.	Thank you for your comment. Recommendation 1.1.8 has been amended to say women should be provided with, or referred to support to make a decision if they request this. The rationale has been expanded to clarify this. The recommendations on support after an abortion (section 1.15) have also been amended to clarify that services should provide, or refer to, counselling services if the woman requests or requires them. The committee did not think it was appropriate to specify where counselling should be provided pre- or post-abortion as some women may prefer to have this within the abortion service to maintain privacy and confidentiality, but others may want independent counselling which has been suggested by other stakeholders.
Church of England: (MPAC)	Guideline	5	7	We **strongly oppose** the introduction of assessment by phone or video link. Some women are pressured into considering or having abortions by social or family pressure or by abusive partners who could exert influence by being present while video or phone consultations take place. Insisting that women attend in person and are seen in private offers the most vulnerable some protection.	Thank you for your comment. It is part of basic clinical practice for healthcare professionals to be alert for signs of physical or emotional abuse or coercion, and therefore not necessary to make a specific recommendation in this guideline. The committee recommended phone or video call assessments as they could help women that are under pressure from families or abusive partners to access services remotely that they would otherwise not be able to do, as well as other reasons for not being able to access services such as location.

Consultation on draft guideline - Stakeholder comments table
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Church of England: (MPAC)	Guideline	5	15	Trainee Healthcare Professionals who have conscientious objection to abortion ought not to be pressured into accepting training positions in provider services, nor should their subsequent careers suffer because of any refusal to accept such positions. This should be reflected in this guidelines (we accept that conscientious objection is written into *some* of the guidelines, but it ought to be made explicit in *all* relevant guidelines)..	Thank you for your comment. The management of conscientious objection is the right of all healthcare professionals and is covered by legislation and relevant guidance (e.g. the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice). Therefore, it is not necessary to make additional recommendations relating to it in this guideline.
Church of England: (MPAC)	Guideline	6	1	It is important that conscientious objection is written into this guideline.	Thank you for your comment. The management of conscientious objection is the right of all healthcare professionals and is covered by legislation and professional guidance (e.g. the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice). Therefore, it is not necessary to make additional recommendations relating to it in this guideline.
Church of England: (MPAC)	Guideline	6	21	Privacy and confidentiality should also extend to guarding women against pressure from family members	Thank you for your comment. The committee agree that information should be kept private from family members unless the women chooses to disclose this. The committee did not make specific recommendations about safeguarding as this is covered by professional guidance (e.g., the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-hub/adult-safeguarding).
Church of England: (MPAC)	Guideline	7	2	This guideline is confusing and potentially misleading. While statistically it might be true, it is not possible to say that any given client will be more or less likely to suffer from long-term physical or mental illness as a result of a	Thank you for your comment. The language of this recommendation has been amended to be clear that this reflects risks at a population, not individual level. However, the committee were aware that evidence from the Academy of Medical

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				termination of pregnancy. In particular, **some women do suffer mental illness related to abortion**. Blanket reassurances, as recommended in the guideline, cannot be safely given.	Royal Colleges showed that women with an unwanted pregnancy are not at a greater risk of mental health problems if they have an abortion compared with continuing pregnancy.
Church of England: (MPAC)	Guideline	11	6	In order for women to make fully informed decisions, it is important that negative as well as positive patient experiences are shared.	Thank you for your comment, the recommendation states that information should be based on women's experiences, without specifying whether they should be positive or negative.
Church of England: (MPAC)	Evidence Review A and Guideline	39 12	14 18	The comment that 'foetal abnormality' forms a ground for termination of pregnancy is inaccurate. It is imperative that correct legal terms are used in the Guideline in order to avoid confusion or misinterpretation of the law. In the context of this Guideline, only 'serious handicap' before 24 week's gestation or 'serious foetal abnormality' after 24 weeks form grounds for termination under the provisions of the 1967 Abortion Act (amended). Using the shorthand term 'foetal abnormality' is misleading and trivialises this ground for termination of pregnancy. It is concerning that the committee took this approach to its review of evidence. It is even more concerning that a section heading on page 12 of the proposed Guideline reads '*Information for women who are having a termination because of **fetal anomaly***. Not only does the term 'fetal anomaly' not appear in the 1967 Act, an anomaly is different from an abnormality (having red hair is anomalous, but it is not abnormal). It is essential that the correct legal	Thank you for your comment, the guideline has been amended to clarify that fetal anomaly refers to abortion under section 1(1)(d) of the Abortion Act 1967.

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				term '**serious** fetal abnormality' is used in this and other Guidelines.	
Doctors for Choice Womens Choice on Abortion UK	Guideline	General	General	**Between 5 and 6** Add in 'Ensure women have the opportunity to ask questions' (essential for informed consent)	Thank you for your comment. The committee did not think it was necessary to include this in a recommendation as it would apply regardless of the procedure and this is covered by professional guidance (e.g., the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent).
Doctors for Choice Womens Choice on Abortion UK	Guideline	General	General	DfC commends those who drew up this excellent guidance. We are particularly pleased about the recommendations on: • service organisation • joined-up care • use of phone/video consultations • maximising the role of nurses and midwives • ensuring trainee HCPs are exposed to abortion care • local specialist centres for women with complex needs/comorbidities • upfront funding for travel and accommodation for those who have to travel for an abortion • all clinically appropriate contraceptive methods are discussed and provided by abortion providers • initial appointments within 1 week of requesting abortion and the procedure within 1 week of the initial appointment • self-referral for abortion	Thank you for your comments.

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				• no rhesus testing or anti d for medical abortions <10 weeks • prophylactic antibiotics for those at increased risk of STIs only for medical abortions • no metronidazole	
Doctors for Choice Womens Choice on Abortion UK	Guideline	General	General	There are some inconsistencies with gestation limits	Thank you for your comment. The gestational limits used in the recommendations on anti-D prophylaxis have been amended to align with recommendations on expulsion at home for early medical abortion. Other dates may have appeared inconsistent due to the language used ('before' and 'after'). This has been checked for consistency and amended throughout (to 'up to and including' and 'after').
Doctors for Choice Womens Choice on Abortion UK	Guideline	General	General	Abortion is a more widely used and understood term generally than 'termination of pregnancy', which ostensibly, is medical jargon that may contribute to abortion-related stigma. DfC would like to see ToP replaced by abortion or abortion care throughout the document.	Thank you for your comments. In response to yours and others' comments the title of the guideline has been amended to 'Abortion Care', and the term 'abortion' has replaced 'termination of pregnancy' in the recommendations.
Doctors for Choice Womens Choice on Abortion UK	Guideline	General	General	Include reference to 'pregnant people' somewhere in the document, even if only as an acknowledgment that not all people who get pregnant and need an abortion are women.	Thank you for your comment. The introductory text to the guideline has been amended to clarify that this guidance is relevant for women and people who are pregnant but do not identify as women.
Doctors for Choice Womens Choice on Abortion UK	Guideline	5	15	Clarify whether this includes medical students and student nurses and midwives – we recommend it does	Thank you for your comment, the recommendation has been amended to include students.
Doctors for Choice Womens Choice on Abortion UK	Guideline	5	22	Before opting out of abortion-related training, those who claim a conscientious objection should engage in a meaningful discussion (e.g. with their	Thank you for your comment. Conscientious objections is covered by legislation and professional guidance (e.g., the General Medical

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				educational supervisor) about what specific aspects of training they would like to opt out of, the potential consequences of opting out and how to mitigate against any adverse consequences.	Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent).
Doctors for Choice Womens Choice on Abortion UK	Guideline	6	15	Could this be phrased in more positive and rights-based language, e.g. "Give supportive care rather than "avoid stigma". Or even 'Counteract abortion-related stigma', giving examples e.g. • Be kind, non-judgemental, respectful and listen to women • Tell women that one in three women have abortions (encourage them to talk to someone they trust) • Avoid the use of value-laden language, such as baby (for fetus) and mother (for pregnant woman). • Avoid negative body language	Thank you for your comment. The committee acknowledges the positivity of your suggestion, however stigma does exist in this area, and was identified by evidence review A as a barrier to accessing services and therefore the committee agreed this wording should remain.
Doctors for Choice Womens Choice on Abortion UK	Guideline	7		**Table** Be specific about what area is being numbed	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists. The wording has been amended to be more specific.
Doctors for Choice Womens Choice on Abortion UK	Guideline	7	2	There is evidence that talking about myths reinforces them rather than dispels them. Telling women abortion doesn't cause breast cancer etc should only be done if the woman brings it up in a consultation.	Thank you for your comment. This recommendation was made based on evidence that women looked on the internet for information and that this may be inaccurate. The committee agreed that reading inaccurate information could create anxiety and delay presentation to services. Therefore, the committee agreed to reiterate guidance from the RCOG and other international

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					authorities, that there is no increased risk of the outcomes listed in recommendation 1.2.1 (infertility, breast cancer and mental health problems).
Doctors for Choice Womens Choice on Abortion UK	Guideline	8		**Table** Replace 'surgery in 'avoids the need for 'surgery' with 'a procedure' or even 'medical procedure' or 'surgical procedure'	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists. The wording you highlight in your comment has been reviewed and updated in the PDA.
Doctors for Choice Womens Choice on Abortion UK	Guideline	8		**Table** Rethink 'May see the pregnancy as it passes'. Be more specific.	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists. The wording you highlight in your comment has been reviewed and updated in the PDA.
Doctors for Choice Womens Choice on Abortion UK	Guideline	8		**Table** Surgical before 14 weeks – be specific about the where the pain and bleeding occurs.	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists. The pain and bleeding section has been rewritten for clarity.
Doctors for Choice Womens Choice on Abortion UK	Guideline	12	5	Bit wishy washy. Discuss recent past use of contraception and need for ongoing contraception. If ongoing need, discuss all appropriate contraceptive methods (including efficacy, key advantages and disadvantages, how to take or insert). Facilitate decision-making and provide chosen method on day, except IUC following	Thank you for your comment. The committee agreed that it would not be appropriate to provide all women with information about contraception, particularly in the context of women having an abortion for fetal anomaly. There was also evidence that women thought the way information about contraception had been delivered was too

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				medical abortion where an insertion appointment should be arranged asap afterwards.	'pushy'. It was not possible to make recommendations about the effectiveness of different methods of contraception as this evidence was not reviewed as part of this guideline. The committee are aware of guidance from the Faculty of Sexual and Reproductive Healthcare about contraception use after pregnancy. This information has been added to the discussion in evidence report B. Recommendations 1.15.1 to 1.15.5 provide further information about providing access to contraception and timing of LARC methods.
Doctors for Choice Womens Choice on Abortion UK	Guideline	13	18	Give more guidance on what constitutes an increased risk of STIs – how to intelligently screen	Thank you for your comment. In response to stakeholder comments, the recommendations for antibiotic prophylaxis for medical abortion have been amended to say they should not be routinely given rather than given to those at risk of STIs as evidence on STI risk was not reviewed as part of this guideline so this population could not be defined. However, the committee agreed that prophylaxis may be appropriate for high risk women or those who would find it difficult to access treatment at a later date in response to a positive screen for sexually transmitted infections. The committee discussion in evidence report D and the rationale and impact has been updated to reflect these changes. There was no question about STI testing within the scope of this guideline so recommendations could not be made in this area. However, a cross-reference to NICE PH3 has now been included which covers guidance on

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					interventions to prevent sexually transmitted infections. PH3 is currently being updated.
Doctors for Choice Womens Choice on Abortion UK	Guideline	21	12	IUC fitted as soon as possible after a medical abortion (not on the same day)	Thank you for your comment. The timing of insertion of IUDs is addressed specifically in recommendation 1.15.4. The committee agreed that including this information in recommendation 1.15.1 may detract from the key point of this recommendation, which is that the full range of methods should be immediately available from the abortion service.
Faculty of Sexual & Reproductive Healthcare Clinical Effectiveness Unit	Guideline	General	General	language **FSRH:** language / terminology Trans-men can have pregnancies and may opt for abortion. A more gender-inclusive use of language is desirable please. It would be possible to refer to "people" and "pregnant people" rather than "women"/ "pregnant women".	Thank you for your comment. The introductory text to the guideline has been amended to clarify that this guidance is relevant for women and people who are pregnant but do not identify as women. However, for simplicity of language, the term women is still used throughout the guideline.
Faculty of Sexual & Reproductive Healthcare Clinical Effectiveness Unit	Guideline	General	General	**FSRH CEU/FSRH:** FSRH supports the use of the word "abortion" not "termination of pregnancy".	Thank you for your comments. In response to your and others' comments the title of the guideline has been amended to 'Abortion Care', and the term 'abortion' has replaced 'termination of pregnancy' in the recommendations.
Faculty of Sexual & Reproductive Healthcare Clinical Effectiveness Unit	Guideline	4	13	**FSRH**: FSRH therefore also support the recommendation that "Commissioners should consider upfront funding for travel and accommodation" for those who have to travel to obtain abortion.	Thank you for your comments.

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Faculty of Sexual & Reproductive Healthcare Clinical Effectiveness Unit	Guideline	5	1 - 24	**FSRH**: FSRH is pleased to note the NICE recommendations on service organisation, particularly those focused on delivering more joined-up care for women including use of phone/video consultations and services in community settings. Like other organisations, we believe that sexual and reproductive healthcare (SRH) - including abortion care - needs to be more broadly integrated into women's healthcare pathways. Consequently, to achieve and enhance recommendations such as those put forward by NICE comprehensively across SRH settings, FSRH, RCOG and the RCGP have produced an evidence-based position statement on Integrated Holistic Commissioning of SRH services. This position statement has been endorsed by the Academy of Royal Medical Colleges (AoMRC). Specifically in relation to abortion our paper points out that abortion rates to women over 30 have been increasing over the last 10 years. Whilst there is no evidence of direct causation, FSRH, RCOG and RCGP are concerned that the increase in terminations of pregnancies for those aged 30 and over may indicate an unmet need for contraception. Additionally, there is significant variation in the provision of contraceptive services and counselling within abortion services, since the level of integration is dependent on the understanding of individual CCG commissioners that contraception should be provided as part of the abortion service. Even when a CCG does fund	Thank you for your comment. Recommendation 1.15.1 should aid services in highlighting the need for the full range of contraception to be available to commissioners.

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				contraception for a specific service, it may still be the case that some methods of contraception are not commissioned; in such situations people experience substantial lack of choice.	
Faculty of Sexual & Reproductive Healthcare Clinical Effectiveness Unit	Guideline	5	12	**FSRH:** To support NICE recommendations focused on workforce and training, FSRH draws attention to three key qualifications we have developed. Their inclusion in the guidance would be of particular use to commissioners, healthcare professionals and those responsible for training curriculums: . 1. The FSRH Special Skills Module in Abortion Care FSRH and Royal College of Gynaecologists and Obstetricians (RCOG) continue to work closely to align our qualifications in this area where viable. 2. The FSRH Diploma Letter of Competence Subdermal Contraceptive Implants Techniques Insertion Only (LoC SDI-IO)	Thank you for your comment, it is not possible to refer to specific changes to curricula as these are likely to change throughout the lifetime of the guideline. The recommendations therefore refer to the principles by which training should be delivered.
Faculty of Sexual & Reproductive Healthcare Clinical Effectiveness Unit	Guideline	5	13	**FSRH:** • FSRH support NICE's recommendation to maximise the role of nurses and midwives in providing abortion care. • FSRH emphasises that training this workforce needs to be properly commissioned. • We support both the NHS and independent providers in playing a role with training.	Thank you for your comment. The recommendations about the workforce in this guideline should support the commissioning of training that will support services to deliver these recommendations.

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Faculty of Sexual & Reproductive Healthcare Clinical Effectiveness Unit	Guideline	5	19 - 24	**FSRH:** FSRH is pleased to note the recommendation that all healthcare professionals who see women requesting abortion have an opportunity in their training to have exposure to/practical experience of abortion care and abortion services. In line with our Personal Beliefs Guidance, we also endorse NICE's recommendation that, on training programmes which include abortion care provision, the only basis for non-participation is opt-out on grounds of conscientious objection which should be formally assessed and annually reviewed.	Thank you for your comments.
Faculty of Sexual & Reproductive Healthcare Clinical Effectiveness Unit	Guideline	6	5	**FSRH**: FSRH have ongoing concerns that current commissioning arrangements, with respect to pregnant people with co-morbidity needing complex care, are inadequate and that complex care at later gestations is provided in very few locations. We are therefore pleased to note the recommendation that "Commissioners should ensure that specialist centres are available as locally as possible, to reduce delays and travel times for women with complex needs or significant comorbidities".	Thank you for your comments. On reflection, as the specification and commissioning framework for specialist abortion services is currently being developed by NHS England, we have amended 'commissioners should ensure specialist centres…' to 'specialist centres should…' to make a distinction between the commissioning framework for this recommendation and other references to commissioners within this guideline.
Faculty of Sexual & Reproductive Healthcare Clinical Effectiveness Unit	Guideline	7		**Table** **FSRH**: FSRH is pleased to see a potentially excellent resource (table 1) that compares medical and surgical abortion options. The formatting and	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists. The

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				layout of this table does however need some further work to maximise impact and value. (There are also inconsistent gestation limits in different sections of this table).	gestational age limits included in the table corresponded to gestational limits in the evidence reviews. However, these are being reviewed in the PDA to make the resource easier to use in practice.
Faculty of Sexual & Reproductive Healthcare Clinical Effectiveness Unit	Guideline	8		**Table** **FSRH:** Some apparent discrepancies within table 1 - such as the difference in the time in the column on Medical treatment (sub-heading before10+1) and description for women (before 10+0) allowed to take misoprostol at home - are due to the current interpretation of the UK law. It seems advisable/desirable to NICE to explain that this discrepancy is due to current interpretation of the law rather than a clinically appropriate/evidence-based recommendation.	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The language and formatting of the decision aid has been amended and does not include this discrepancy between 10+0 and 10+1. It is clear in the decision aid that whether or not you can take the medicine at home is dependent on gestational age and legal restrictions.
Faculty of Sexual & Reproductive Healthcare Clinical Effectiveness Unit	Guideline	12	4	**General and page 4** **FSRH:** People have the right to choose a medically appropriate procedure that best suits their needs and to have assessment and treatment without delay. FSRH fully supports the recommendation aiming to provide people with an initial appointment within 1 week of requesting abortion and the offer to have procedure being made within 1 week of the appointment. We are pleased to note the various recommendations on provision of information and the recommendation that women should be allowed to self-refer for abortion care.	Thank you for your comments.

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				The FSRH Clinical Unit Effectiveness Unit (FSRH CEU) does however make the below recommendation (see point 8).	
Faculty of Sexual & Reproductive Healthcare Clinical Effectiveness Unit	Guideline	12	5 - 6	**1.2.6** **FSRH CEU:** P12 1.2.6, lines 5 and 6 "Ask women if they want information on contraception, and if so provide information about the options available to them." • Should this conclude with a phrase like "and how they can access these"? A person might like the idea of an IUS or an implant, but could be deterred because they think there would be a lot of effort involved in accessing them.	Thank you for your comment, recommendation 1.2.6 has been amended to include a cross reference to the 'Improving access to contraception' section that states that contraception should be provided on the same day as the termination, or as soon as possible afterwards as appropriate.
Faculty of Sexual & Reproductive Healthcare Clinical Effectiveness Unit	Guideline	13	4	**FSRH**: FSRH welcomes the proposed recommendation to reduce the use of anti-D in early medical abortion in line with current recommendations for women with medical management of miscarriage. This will assist providers to stream-lined care and support more locally delivered services and reduce unnecessary visits for people undergoing early medical abortion.	Thank you for your comments.
Faculty of Sexual & Reproductive Healthcare Clinical Effectiveness Unit	Guideline	13	16 - 17	**1.4.1** **FSRH CEU/FSRH:** "Only give antibiotic prophylaxis to women who are having a medical termination of pregnancy if they have an increased risk of sexually transmitted infections."	Thank you for your comment. In response to stakeholder comments, the recommendations for antibiotic prophylaxis for medical abortion have been amended to say they should not be routinely given rather than given to those at risk of STIs as

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		32	17-19	• How is "increased risk" defined? There is no reference to making an STI risk assessment or to testing. There needs to be some indication how this "increased risk" status is arrived at. FSRH welcomes the proposed recommendation to reduce the use of prophylactic antibiotics but notes that there is no guidance to support providers in identifying "those at the highest risk for STIs" in a population with unwanted pregnancies within the document. NICE should add such guidance to the guidelines.	evidence on STI risk was not reviewed as part of this guideline so this population could not be defined. However, the committee agreed that prophylaxis may be appropriate for high risk women or those who would find it difficult to access treatment at a later date in response to a positive screen for sexually transmitted infections. The committee discussion in evidence report D and the rationale and impact has been updated to reflect these changes. There was no question about STI testing within the scope of this guideline so recommendations could not be made in this area. However, a cross-reference to NICE PH3 has now been included (under the section on preventing infection) which covers guidance on interventions to prevent sexually transmitted infections. PH3 is currently being updated.
Faculty of Sexual & Reproductive Healthcare Clinical Effectiveness Unit	Guideline	21	7	**FSRH:** FSRH is pleased to note the recommendation that commissioners and providers should ensure the full range of contraceptive methods is discussed when the woman wishes it and that a method clinically appropriate and chosen by the woman is available and provided to her within the abortion care setting. ***The FSRH Clinical Effectiveness Unit (FSRH CEU) does however recommend an amendment to this section (see point 11).***	Thank you for your comments.

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Faculty of Sexual & Reproductive Healthcare Clinical Effectiveness Unit	Guideline	21	7-12	**1.12.1** **FSRH CEU:** "Commissioners and providers should ensure that the full range of reversible contraceptive options (depot medroxyprogesterone acetate [DMPA], contraceptive implant, intrauterine methods, oral contraceptives, contraceptive patches, vaginal rings or barrier contraception) is available for women on the same day as their surgical or medical termination of pregnancy." • This can't really be applied to IUC insertion for people who have early medical discharge or home miso and abortion at home. Does there need to be a caveat to cover this?	Thank you for your comment. The timing of insertion of IUDs is addressed specifically in recommendation 1.15.4. The committee agreed that including this information in recommendation 1.15.1 may detract from the key point of this recommendation, which is that the full range of methods should be immediately available from the abortion service.
Faculty of Sexual & Reproductive Healthcare Clinical Effectiveness Unit	Guideline	55	13	**FSRH:** FSRH welcomes NICE signposting HCPs to additional information and resources. A challenge for healthcare is the misinformation on abortion that people receive in non-medical settings. With this in mind, we recommend NICE reference the "*FSRH RCOG Abortion and Abortion Care Factsheet: To support Relationships and Sex Education in secondary schools*". The factsheet is **a free resource** for professionals in secondary schools to use in relationships and sex education (RSE) lessons. It aims to ensure that professionals involved in educating young people have a factually accurate, unbiased and evidence-	Thank you for your comment, this reference will be passed onto the publishing team at NICE.

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				based source of information about abortion in the UK.	
International Campaign for Women's Right to Safe Abortion	Guideline	General	General	The language of "having a termination" and "providing a termination" and "performing an abortion" is the language of aspiration/surgical methods where someone does the abortion. With abortion pills, there is not provision or a provider in the same sense of the word. The language of this guidance should be checked throughout to reflect this difference.	Thank you for your comment. The committee have checked through the document but decided that the language used was clear.
International Campaign for Women's Right to Safe Abortion	Guideline	General	General	Considering the most forward-looking, up-to-date service delivery information available both from the World Health Organization guidelines and from countries such as in Scandinavia and Canada, I'm sorry to say that I find much of the language in this guideline still based in a 20th century perspective, that is, using standard language from the past that does not reflect the kinds of changes that new technology and new ideas for service delivery being researched and tried could deliver. Specifics will emerge as I go through the draft guidelines. Overall, I strongly recommend that you read the new Canadian guidelines on medical abortion and adopt their policies. See for example: • Wendy V Norman, Sara Munro, Melissa Brooks, et al. Could implementation of mifepristone address Canada's urban–rural abortion access disparity: a mixed-methods implementation study protocol. BMJ	Thank you for directing us to the protocol for the planned study in Canada. The committee acknowledge that there is much ongoing research in service delivery. The recommendations made are on the basis on published evidence, and therefore cannot take the research you have cited into consideration at this point. The guideline does however contain research recommendations and it is likely that the current and planned research that you allude to will be used to inform future update of this guideline.

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				Open 2019;9:e028443. DOI: 10.1136/bmjopen-2018-028443 • Global News Canada, by Amanda Connolly, 16 April 2019 ; Newswire Canada, by Health Canada, 16 April 2019	
International Campaign for Women's Right to Safe Abortion	Guideline	General	General	I am really opposed to the usage of, e.g. 10^{+1}, 23^{+6}, to talk about length of pregnancy and the continuing reliance on ultrasound you support to try to date a pregnancy so precisely. I heard a sorry tale last week of a woman who had to be sent to 3 clinics in different parts of England before she could have a second trimester abortion (they all used different protocols that depended on this sort of precision). Three ultrasound scans to date her pregnancy resulted in widely differing readings. Not just a difference in number of days but in number of weeks of pregnancy, trying to determine whether she was at or approaching 24 weeks. So I think it is a mistake that you talk about length of pregnancy as if it can be pinpointed to weeks+days. This is myth-making, not based on scientific evidence. Moreover, there is no advantage to women of this kind of "dating" either; indeed, it can create barriers that are used to stop women having legal abortions wittingly or unwittingly. It is based on and expresses a fear of going over 24 weeks, as if the police are at the door waiting to arrest everyone. This has to be challenged/rejected for many obvious reasons. Part of the meaning of "decriminalising abortion" is	Thank you for your comment. Using the language of weeks and days is consistent with how gestation is dated across obstetric services in the UK, not just in the area of abortion. It is also necessary to use this language to ensure compliance with the Abortion Act and it is beyond the scope of this guideline to address 'decriminalising abortion'. However, this guideline is not recommending that everyone needs an ultrasound to date pregnancy prior to abortion; the number of weeks and days of gestation can be calculated from date of last menstrual period.

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				to move away from this sort of rigidity, not continuing to impose it.	
International Campaign for Women's Right to Safe Abortion	Guideline	3		**Recommendations** The marketing authorisations for misoprostol and for mifepristone are very out of date. The current (2012) and the new World Health Organization (WHO) guideline (in preparation at this writing) should be consulted and followed. For mifepristone, for example the use of 600mg has not been recommended by WHO for many years.	Thank you for your comment. It is NICE policy to state marketing authorisations according to the summary product characteristics. However, the recommendations have been made based on best available evidence, not marketing authorisations.
International Campaign for Women's Right to Safe Abortion	Guideline	4	11 - 12	The statement "Healthcare professionals should not allow their personal beliefs to delay access to termination of pregnancy services." will continue to fall on deaf ears in the future as much as in the past. The guideline should advise healthcare professionals to find work that avoids them wanting to impose their beliefs on women that stop or delay them from obtaining abortions because personal beliefs should not be part of the delivery of healthcare. It would be best to alter the referral system for abortion so as to ensure that such healthcare professionals have to declare their views and ensure they cannot allow their personal beliefs to affect access to care.	Thank you for your comment. The committee did not think that this recommendation needed expanding as it is consistent with professional guidance (e.g., the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice) and it is not the focus of this guideline to provide further guidance on this. Additional information has been added to the rationale to clarify this.
International Campaign for Women's Right to Safe Abortion	Guideline	4	13 - 14	Similarly, if there is nothing in policy forcing commissioners to provide for travel costs, given the terrible shortage of funding, nothing will happen.	Thank you for your comment. The committee were not able to make a stronger recommendation for upfront funding based on the evidence available.
International Campaign for Women's Right to Safe Abortion	Guideline	4	21 - 24	Given the reality of how medical abortion pills should change service provision, a one-week waiting period between the assessment for an	Thank you for your comment. The committee agreed that 1 week was a reasonable timeframe when considering different types of procedures,

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				abortion and providing women with the pills should never occur. The guideline should differentiate re the time required for women seeking early medical vs surgical termination. MA pills are effective as soon as a woman realises she is pregnant, even before six weeks (see Efficacy of medical abortion prior to 6 gestational weeks: a systematic review by Nathalie Kapp et al, Contraception 2018. At the first appointment, the assessment, she should be able to obtain the pills or a prescription for them immediately. Moreover, while 2 weeks may seem a short period of time to wait for an MVA/VA compared to the past (it's of course far better than 4 or 5 or 6 weeks waiting, as in the past), but ideally it too should be shortened. Although your text may not have intended to say that a wait of 2 weeks for an abortion is acceptable, the current text does imply that it is.	possible need for referrals and need to determine medical eligibility. However, the rationale has been amended to make it clear that same day services can be provided where possible.
International Campaign for Women's Right to Safe Abortion	Guideline	5	4 - 5	It isn't clear why you mention "compulsory counselling or compulsory time for reflection". These are not required here. If there is evidence they are happening, however, this wording should be strengthened to say that there is no legal or regulatory basis for this and that it violates women's rights. I note that you say much later on that this is stated because it happens in other countries, but you do not make this clear on this page.	Thank you for your comment. The committee agreed that it was important to make this recommendation as, although there isn't a legal requirement, there have been suggestions that this is necessary and attempts to introduce this. The rationale has been amended to explain that compulsory time for reflection and counselling is not a legal requirement.
International Campaign for Women's Right to Safe Abortion	Guideline	5	9 - 11	The guideline should be stronger re the fact that hospitals should no longer have the main role of providing first trimester abortions (90% or so of	Thank you for your comments, the recommendations made were appropriate to the level of evidence identified in Evidence Report A

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				total abortions). I would also have liked to see this guidance promote provision of first trimester abortions in the community as a goal alongside the promotion of GPs, nurses and midwives as the main health professionals managing/providing both contraceptives and abortions. This is an example of continuing to promote 20th century standards when so many things should have changed. I am aware that the law requires both these things currently, but if the guideline could find space to make recommendations that are about needing to change the law and regulations in order to implement what is now considered best practice (see WHO guidelines) that might help to move our services into the 21st century.	regarding the location of services. It is beyond the remit of NICE guidelines to make recommendations about any legislation.
International Campaign for Women's Right to Safe Abortion	Guideline	6	15 - 24	1.1.17 and 1.1.18. Both of these sections should be phrased in more positive and rights-based language than this. Not "avoid stigma" but "Give supportive care", for example. Most women are not trembling with fear when seeking an abortion anymore. They know what they want and need. You can say: Negative and judgmental comments have no place, as is the case with all healthcare provision. You can say: Women have a right to privacy and confidentiality. Information about them must not be shared with anyone not directly involved…	Thank you for your comment. The language used is consistent with the qualitative evidence reviewed and the experience of the committee.
International Campaign for Women's Right to Safe Abortion	Guideline	7		**Table 1** To say that general anaesthesia should be available for first trimester aspiration abortion is really backward-looking. The only person who needs it is the doctor who doesn't want to have to	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The committee agreed in the absence of evidence of any method of anaesthesia being superior to

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				deal with the woman except as an inert object. WHO does not recommend GA (I'm not sure about D&E) but certainly not otherwise.	any other that women should be offered the choice and the differences between methods explained.
International Campaign for Women's Right to Safe Abortion	Guideline	7	2 - 4	1.2.1. This false information is what anti-abortion people tell women. The reassurance should be positive – abortion is one of the safest of all medical processes/procedures, complications of any kind, especially serious ones, are very rare and almost always easily treatable. Women feel above all relief when it's over, that their lives are back in their own hands. Anything negative they have heard from the anti-abortion movement about risks of abortion is false and intended to frighten them. This doesn't mean complications never happen but they are rare and can be treated.	Thank you for your comment. This recommendation should combat this.
International Campaign for Women's Right to Safe Abortion	Guideline	7	5 - 7	The risks of abortion are minimal. Instead of talking only about benefits and risks, the text should talk about how the two kinds of methods differ and why women tend to choose one or the other. As you say with Table 1, for women this is really about preferences today. By all means they must warn re signs of complications. Maybe you think that is the same as risks, I think it's different in how it should be presented.	Thank you for your comment. This recommendation has been amended to include 'taking account of their needs and preferences'.
International Campaign for Women's Right to Safe Abortion	Guideline	8		**Table 1** – Medical abortion is not "performed". – Additional doses of misoprostol may also be needed before 10 weeks though not very often. But should be available. – "This may cause bleeding and pain." (4th column) isn't clear where the bleeding will come	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists. The wording you highlight in your comment has been reviewed and updated in the PDA: 'performed' is

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				from as the previous sentence is about "cheek and gum".	not used; the need for some women having an early abortion to take extra doses of misoprostol is noted; the pain and bleeding section has been rewritten for clarity.
International Campaign for Women's Right to Safe Abortion	Guideline	9		**Table 1** Women bleed less after surgical than medical because the aspiration/surgery removes most of the products/blood/fluid. Shouldn't that be made clearer as it's intended for telling women?	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The committee agreed that the current wording gave sufficient detail as evidence from the qualitative review (see evidence report B) showed that women wanted information about what they will experience.
International Campaign for Women's Right to Safe Abortion	Guideline	10		With new research on using repeat doses of misoprostol showing that a complete abortion can be achieved in almost all cases, I wonder if the numbers of incompletes among the 1000 women shouldn't be revised. It may not be possible to give numbers yet, as this research is ongoing, but you should surely not continue to give data not based on repeat doses. WHO data from 2002 as footnoted twice are really old. Have you asked the WHO authors referenced if they still share those figures? You can: they are still at WHO (Lale Say and Metin Gülmezoglu).	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. As the research you have identified has not yet been published it is not possible to include it in the guideline or PDA. This will be highlighted to the NICE surveillance team to be aware of when conducting update searches in the future.
International Campaign for Women's Right to Safe Abortion	Guideline	11		**Table 1 end** Are long-acting contraceptive methods the only ones being recommended these days? What happened to women's choice of method? I know you list most methods later on but…	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists. The PDA will list all forms of contraception mentioned in the NICE guideline, with the following wording: "*You can start contraception straight away after an*

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					abortion. You can choose whichever type of contraception is best for you, and your healthcare professional can help you decide. There are long-acting methods available, and with these you don't have to take a pill every day. Long-acting contraceptives include injections or implants, or an IUD (the coil) or IUS (hormonal coil) placed in the womb (called 'intrauterine' devices or systems). Other methods of contraception include oral contraceptives, contraceptive patches, vaginal rings or barrier contraception (for example, condoms).'
International Campaign for Women's Right to Safe Abortion	Guideline	12	7 - 10	Do you really want to talk about the products as "the pregnancy"? I know this is a difficult terminology issue but what about a one-sentence description because that's what women need to be given so they don't think a small baby will come out. Photo? There is one of a 4 and a 6 week embryo from a paper in Reproductive Health Matters – https://www.tandfonline.com/doi/full/10.1016/S0968-8080%2810%2935501-7 (towards the end of the paper) you could use it, for example.	Thank you for your comment. The term pregnancy has been used for simplicity and consistency with other recommendations. As what the pregnancy may look like will differ depending on gestation, it was not possible to include a sentence or photo to describe this that would be applicable at all gestations.
International Campaign for Women's Right to Safe Abortion	Guideline	15	10 - 12	Can you not be more positive, and indeed insistent, about the safety of having an early abortion without depending on ultrasound? WHO has been saying that routine ultrasound is not required for years now. See their 2012 guidance that was written several years before it was even published.	Thank you for your comment. The evidence on whether an ultrasound should or should not be undertaken was not reviewed as part of this guideline. Therefore, the committee could not make recommendations in this area. However, a future update of the guideline may consider that question.

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International Campaign for Women's Right to Safe Abortion	Guideline	16	5 - 7	If the woman takes the abortion pills at home, she will have more than just "expulsion". Say something like "a period of cramping and pain, leading to expulsion of the pregnancy".	Thank you for your comment. This information is covered by recommendation 1.2.3 which recommends providing women with information about what to expect and how much pain and bleeding there is likely to be. This is also covered in a patient decision aid that will be published alongside the final guideline.
International Campaign for Women's Right to Safe Abortion	Follow-up and support	21	8 - 13	You've left out mentioning condoms and other barrier methods in the list of contraceptives. All other methods are named. Why not those? Think HIV/STIs.	Thank you for your comment. Barrier methods are included in recommendation 1.15.1 in the list of the full range of contraceptive options that should be available on the day of the termination.
International Campaign for Women's Right to Safe Abortion	Recommendations for research	22	21 - 23	Re anti-D prophylaxis, see the new Canadian guideline and also the multi-country/multi-authored May 2019 paper at https://www.contraceptionjournal.org/article/S0010-7824(19)30053-8/pdf	Thank you for your comment. The committee agreed that both articles underscore the need for further research examining this question as their recommendations are also based on consensus and not evidence directly comparing the use of anti-D prophylaxis to no prophylaxis in RhD negative women undergoing abortion.
International Campaign for Women's Right to Safe Abortion	Rationale and impact	25 ff	General	"The committee recognised that it is not possible for all services to offer terminations every day of the week." – Again, a distinction between what is reasonable with medical vs. surgical abortion should be made in a statement like this. The easy way of making medical abortion pills available every day of the week is by including telemedicine services and pharmacists in the picture. I have published research from Nepal, one of the poorest countries in the world, that shows that pharmacy workers with simple training in provision of abortion pills can do so safely. Again, Canada has moved quickly forward with involving pharmacists and visits via telemedicine in making abortion pills	Thank you for your comment. The committee agreed it was not appropriate to make a distinction between medical and surgical abortion in this context as it is important to preserve women's' choice. Further, current regulations mean that the pills for medical abortion have to be dispensed at approved premises, and cannot be issued/prescribed by pharmacists/GPs. Therefore, for some services, it is not feasible to provide medical abortions every day. The committee did consider evidence from outside of the UK, but the reviews in evidence report A only included evidence from OECD countries (excluding those where abortion is prohibited or only done to save

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				easily accessible. The Tabbot Foundation in Australia was providing abortion pills daily by telemedicine with only one or two teams of providers per state. WHO 2015 and 2018 guidelines on mid-level providers confirm through their review of research that pharmacists can provide MA pills safely. Moreover, the death of family planning clinics and the move to GP provision of contraception was short-sighted. These specialist clinics could perhaps be attached to GP services in each area, but should once again be recommended for the 21st century and include first trimester abortion services – pills and aspiration abortions could/should be available from them – along with contraception. Training is key. The agreement of obstetrician-gynaecologists to step back and hand most abortion care over to nurses and midwives is also critical to changing the current situation, alongside changing the regulations allowing them to do so. In many countries this is already allowed but the ob-gyns will not let go of the services or are blocking the change needed in the law and/or regulations to allow it. I note in several places that you say "there was no evidence…". I apologise if I am mistaken, but it appears on the surface at least that you did not look outside Great Britain for evidence. The World	the woman's life) as the committee agreed that factors that help or hinder accessibility and sustainability of abortion services may differ in non-OECD countries and when abortion is more restricted. The WHO guidelines would not have been included as they are international and include studies that do not meet our inclusion criteria and do not report results of studies conducted in OECD and non-OECD countries separately. Similarly, a large number of the papers in the special issue of Contraception were not conducted in OECD counties and some are not comparative studies, and therefore would not have met our inclusion criteria for the question on strategies to improve access. Further, the May 2019 issue of Contraception was published after our search date and, therefore, these studies would not be eligible for inclusion. The consultation process was open to any organisation that wished to register, however this process is now completed.

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				Health Organization guidelines (four of them – 2012, 2014, 2015, 2018 and new guidance to replace the 2012 ones in the pipeline) are critical. The research evidence from Scandinavia and Canada about medical abortion, much of which is in English, is equally important. On medical abortion, a number of the papers in this Special Edition of Contraception are apropos: https://www.contraceptionjournal.org/content/contra-medical-abortion-special-issue as are some of the papers in the May 2019 edition of Contraception at: https://www.contraceptionjournal.org/current Lastly, I urge you to share this draft text of the guideline for comment with two people who I look to as international experts (and am happy to supply details if requested): 1. Beverly Winikoff, Gynuity Health Project, USA – co-author on the anti-D article referenced above. 2. Wendy Norman, MD, MHSc, University of British Columbia, Canada – co-author on the article from Canada referenced above.	
Life	Guideline	General	General	Life is a charity which offers housing, support and counselling to thousands of women facing unplanned or crisis pregnancies each year. Our service, which has existed for 50 years, aims to create a safe space for women to explore and consider their emotions, free from external	Thank you for your comment. This guideline does not cover the time period before a women has requested an abortion and there is evidence (Cameron 2013) that most women (93%) are certain of their decision to not continue a pregnancy at the point at which they request an

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				pressures. It is our concern that the NICE guidance, in its present form, will result in women being rushed through the abortion process; something patients have expressed concern about in recent years.	abortion. Therefore, once a women has requested an abortion she should not be faced with unnecessary delays due to the organisation of services. However, recommendation 1.1.7 was included to ensure that women can wait longer to have an abortion if they would prefer this for whatever reason, including if she is still considering her options. Recommendation 1.1.8 has also been amended to say women should be provided with, or referred to support to make a decision if they request this. The rationale has been expanded to clarify this.
Life	Guidelines	General	General	It would appear that cost-cutting is one of the greatest motivating factors behind streamlining the abortion process.	Thank you for your comment. The attempt to streamline the abortion process was in response to: 1) evidence that morbidity and mortality rates increase for every additional week of gestation, 2) the fact that women have a greater choice regarding type of procedure at earlier gestations, and 3) evidence that decreasing waiting time was an important avenue for improving care (please see the committee discussion of the evidence in evidence report A). Posited cost savings are a result of recommendations, not the reason for them.
Life	Guideline	General	General	When taken as a whole, the recommendations in the NICE draft guidelines on abortion provision create conditions for women to be rushed through the abortion process. Throughout the guidance, it appears that speed and cost-cutting take paramount over patient safety and acting in a woman's best interest. The result of recent CQC inspections in recent years has demonstrated how	Thank you for your comment. The attempt to streamline the abortion process was in response to: 1) evidence that morbidity and mortality rates increase for every additional week of gestation, 2) the fact that women have a greater choice regarding type of procedure at earlier gestations, and 3) evidence that decreasing waiting time was an important avenue for improving care (please

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				a conveyor belt culture present amongst some private abortion providers has jeopardised women's health.	see the committee discussion of the evidence in evidence report A). Therefore, in most circumstances, speed of treatment is: 1) in the woman's best interest, as this is less distressing to the woman and will result in greater choice, and 2) is prioritising patient safety, as having an earlier abortion is associated with fewer complications. However, recommendation 1.1.7 was included to allow women to have a longer wait if they would prefer this, to avoid women being pressured to meet the timelines set out in recommendation 1.1.6. The rationale has been expanded to acknowledge that some women might want extra time to consider their decision after the assessment. The purpose of NICE guidelines is to set standards for care and, when the guideline is considered as a whole, the recommendations promote safe and effective treatment in a timely manner. Posited cost savings are a result of recommendations, not the reason for them. It is outside the remit of a NICE guideline to comment on individual CQC findings.
Life	Guideline	1	5	1. We believe that the stated aim of the draft guidance, to "*improve the organisation of services to make it easier for women to access a termination*" is a flawed starting point. This objective streamlines a procedural pathway geared towards *one* outcome only: abortion. If the medical profession truly seeks to improve patient care in the event of an unplanned pregnancy, then it is crucial to take the	Thank you for your comment. The Department of Health and Social Care asked NICE to develop a guideline on abortion care. The purpose of the guideline, and improving access to services, is to ensure that abortions are conducted under the safest circumstances possible. The care between conception and the request for abortion was outside the scope of this guideline.

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				patient's potentially complex circumstances as its starting point, not defining the outcome prematurely.	
Life	Guideline	4	9 - 10	By encouraging "*self-referrals*" directly to abortion providers, thereby circumventing consultations with a GP, the patient loses an opportunity to talk through their options with an impartial professional and potentially receive emotional support. While private providers such as BPAS and Marie Stopes International may claim to offer similar services in relation to counselling, they cannot be impartial due to their financial incentive of the woman choosing an abortion. For example, in 2017, the Care Quality Commission accused Marie Stopes of paying bonuses to staff who encourage women to have abortions. This was corroborated by Marie Stopes staff at Maidstone who told inspectors that the clinic was like a "cattle market" and described a "very target-driven culture". Furthermore, In 2017, ComRes polling showed that 93% of women want independent abortion counselling introduced. The advice therefore, to encourage "*self-referrals*" directly to private abortion providers, goes against what the majority of women want with respect to their own care, placing an emphasis instead on speed and cost-saving.	Thank you for your comment. Recommendation 1.1.2 says women should be allowed to self-refer to services. This recommendation was made in response to evidence that there can be delays getting GP appointments, that physicians can obstruct access to abortions and that women are seen quicker if they self-refer compared to if they are referred by a healthcare professional. However, this recommendation is not prioritising self-referral over a consultation with, and referral from, a GP and this option is still available for women who would prefer this. Self-referral also does not preclude the option of independent counselling, but this should not be a requirement. However, recommendation 1.1.8 has been amended to say women should be provided with, or referred to support to make a decision if they request this, in response to yours and others' comments.
Life	Guideline	5	4 - 5	It is disappointing that the guidance directs professionals not to give "*compulsory time for reflection before the termination of pregnancy*". Reflection periods ensure that a woman considering an abortion has enough time to	Thank you for your comment. Compulsory time for reflection is not a legal requirement in the UK; this information has been added to the rationale and impact section for waiting times. There is evidence (Cameron 2013) that most women (93%) are

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				examine all of the options available to her. This advice contributes to the tone of the document which seemingly places speed and immediacy above concern for patient well-being. The removal of waiting times also proves to be out of step with what the majority of British women want, with 78% of women in the UK expressing their support for a five-day consideration period before abortion in a 2017 poll.	certain of their decision to not continue a pregnancy at the point at which they request an abortion. Therefore, once a women has requested an abortion she should not be faced with unnecessary delays if she is sure of her decision. However, recommendation 1.1.7 was included to ensure women can wait longer for an abortion if they would prefer this.
Life	Guideline	5	7 - 8	Removing GP consultations and promoting termination of pregnancy consultations with private providers by phone or video call raises particular concerns. Reports of abortions being signed off by Marie Stopes after telephone discussions as short as 22 seconds fails to demonstrate patient-centred practice or providers acting in the patients' best interests. Promoting video or phone consultations may also result in key opportunities to identify vulnerable patients being missed, as well as key medical history which may be crucial for patient safety. It is unlikely that a phone call with an abortion provider, potentially less than a minute long, would be able to identify a woman who is suffering from domestic violence or a young person being pressured into an abortion by relatives. (This is particularly relevant in light of a 2014 study of London abortion clinics which showed there was a six times higher rate of intimate partner violence in women undergoing abortion compared with women receiving antenatal care - *Wokoma TT et al (2014) A comparative study of the prevalence of*	Thank you for your comment. It is part of basic clinical practice for healthcare professionals to be alert for signs of physical or emotional abuse or coercion, and therefore not necessary to make a specific recommendation in this guideline. The committee recommended phone or video call assessments as they could help women that are under pressure from families or abusive partners to access services remotely that they would otherwise not be able to do, as well as other reasons for not being able to access services such as location. Clinicians conducting an assessment remotely have a duty of care to cover the same aspects, including medical history and safeguarding concerns, as they would in a face to face consultation. However, there was not a review question about content of assessment within this guideline and so further detail on what should be included cannot be provided. It is outside the remit of a NICE guideline to comment on individual CQC findings.

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				domestic violence in women requesting a termination of pregnancy and those attending an antenatal clinic. BJOG 121:627-633).	
Life	Guidelines	5	7-8	From a medical perspective, phone consultations for women with complex comorbidities would also be unsuitable. Similarly, if a private abortion provider has not identified a woman as having an active or latent STI over the phone, proceeding with an abortion in this scenario could cause long-lasting and detrimental consequences to the patient's reproductive health.	Thank you for your comment. The guideline has been amended to signpost readers to NICE guideline PH3 on Sexually transmitted infections and infections and under-18 conceptions: prevention which provides guidance on interventions to prevent sexually transmitted infections. PH3 is currently being updated. The guideline also recommends the use of prophylaxis antibiotics for those undergoing a surgical abortion. If there are concerns about complex comorbidities, clinicians should follow recommendations 1.1.15 and 1.1.16 and the service specification that is currently being developed by NHS England.
Life	Guideline	5	19 - 24	Another key concern is the objective to increase the integration of abortion training for medical and midwifery students. Although NICE recognises the right to conscientiously object to abortion, positioning the training as *"essential*" (p27, line 11), puts an undue burden on students who do morally object to what is undeniably a controversial procedure. By creating a culture which makes conscientious objection more difficult to assert, the right is being respected in name only.	Thank you for your comment. Recommendation 1.1.12 says that midwives, nurses, GPs and medical students should have the chance to gain experience in abortion services, not that abortion training should be integrated into curricula. The statement that training is 'essential' is referring to recommendation 1.1.13, which is limited to specialities that already have abortion training as part of the core curriculum (e.g., obstetricians and gynaecologists), and is in response to evidence that 1 in 5 pregnancies (excluding miscarriage) end in abortion (Office for National Statistics 2018). Not enough new trainees are acquiring skills needed to perform abortions and, therefore, abortion services will not be sustainable in the

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					future unless this changes. This recommendation does not make it more difficult for those with a conscientious objection to assert this and recommendation 1.1.13 includes a clause about opting out due to conscientious objection.
Life	Guidelines	7	2 - 4	In terms of counselling, it is highly problematic that the NICE guidance directs medical professionals to tell women that "*having a termination of pregnancy does not increase their risk of long-term health problems…such as… mental health issues*" without citing an evidence base for this assertion. It is possible that NICE may be relying on the 2011 review by the Academy of Medical Royal Colleges, *Induced Abortion & Mental Health*, to make this claim. This study noted that "*the rates of mental health problems for women with an unwanted pregnancy were the same whether they had an abortion or gave birth*". The report did concede, however, that "*the most reliable predictor of post-abortion mental health problems was having a history of mental health problems before the abortion*." This is significant given that the Adult Psychiatric Morbidity Survey (the only national source of information on rates of treated and untreated mental illness) has stated that as many as one in five women in the UK have a common mental disorder, with rates having steadily increased in women since 2000. Setting aside the likelihood that women with mental health conditions may be an overrepresented group amongst the 200,000 women who have abortions in the UK every year (as those with mental health	Thank you for your comment. The evidence for this recommendation is explained in both the rationale section of the guideline and the committee discussion in evidence report B. The committee were aware that the Academy of Medical Royal Colleges guidance showed that following an unwanted pregnancy, there was not an increased risk of having mental health problems in women who had an abortion compared with those who have birth. It is not clear if any mental health problems following an abortion in a woman with previous mental health problems are due to the abortion or the fact that people who have a history of mental health problems are more likely to experience mental health problems in the future. Therefore, the committee concluded that there was no robust evidence of a link between abortion and mental health problems.

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				problems may feel less able to continue with an unplanned pregnancy), conservatively applying the one in five figure still leaves 40,000 women across the UK every year at risk of developing potentially serious mental health problems following an abortion.	
Life	Guideline	7	2 - 4	The assertion that having a termination does not increase increase a woman's risk of mental health issues does not correspond with the post abortion clients that use Life's services each year. Women of all ages seek out our services to help them process the intensity of their emotional and psychological issues. Thus, telling all women, irrespective of their medical history, that there are no long-term psychological ramifications to having an abortion is imprudent at best and reckless at worst. This is particularly true in situations where a pregnancy may have been "wanted" but the patient felt that had "no choice" but to terminate, perhaps due to financial reasons or a difficult relationship.	Thank you for your comment. The language of this recommendation has been amended to be clear that this reflects risk at a population, not individual level. However, the committee were aware that evidence from the Academy of Medical Royal Colleges showed that women with an unwanted pregnancy are not at a greater risk of mental health problems if they have an abortion compared with continuing pregnancy. The committee did not make recommendations about women with 'wanted' pregnancies as available guidance has not considered evidence for this subgroup separately.
Life	Guideline	21	20	It is regrettable that NICE only directs health professionals to suggest the offer of counselling *post* abortion. If potential emotional repercussions are a reasonable plausibility for some women, it seems logical that counselling should at least be offered prior to undergoing a termination, as well as after. This would also provide further opportunities for mental health screening to identify patients at risk of psychological problems post-abortion. One client shared her experience of how she	Thank you for your comment. There is no legal requirement for an enforced waiting period or counselling prior to an abortion. This information has been added to the rationale. Further, there is evidence (Cameron 2013) that the majority of women (93%) are sure of their decision to proceed at the point of request. However, recommendation 1.1.8 has been amended to say that women should be provided with, or referred to support to make a decision if they request this.

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				wished she had been listened to prior to her abortion and how she struggled with the consequences for many years afterwards: "*Society doesn't allow you to feel guilty or grieve for my lost babies, because when you do try to say to your partner or friends or relative how you are feeling all you get back is 'it was your decision' – no it was never my decision, all I kept hearing was 'you are doing the right thing', no one ever asked me how I was really feeling or told me how I would be totally consumed by the terrible grief and the loss of part of me. Over the years I have just bottled it all up, trying not to face the pain, speaking about it now is lifting an all-consuming weight from me*". This testimony goes to show that for some women, years of suffering could be avoided if they are given adequate space *before* having an abortion to explore their feelings and determine whether this is something they really want, or is it something they feel they are expected to do.	
Life	Guideline	26	5 - 7	The guidance asserts that "*substantial cost savings can be achieved if women present earlier for termination of pregnancy. Most of this saving comes from women having a medical rather than a surgical termination*". This seems to conflict with earlier advice on p7, line 5, which instructs medical professionals to "*provide information about the benefits and risks of medical and surgical termination of pregnancy*" and to do so "*without being directive, so that women can make their own choice*". If hastening the abortion	Thank you for your comment. The statement that "most of the saving comes from women having a medical rather than a surgical termination" is based on the 2017 National Abortion Statistics that show over 90% of terminations up to 10+0 weeks gestation are medical terminations. Therefore, there is an increased likelihood that an earlier termination may be medical rather than surgical. However, this does not mean that women having a termination earlier will be encouraged to choose a medical termination rather than a

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				process de facto results in an increase in medical terminations, which benefits the NHS financially, it is hard to see that women's "choice" is being respected as claimed. It must also be noted that a medical abortion can be more distressing for the patient who may have to "*see the pregnancy as it passes*" (p8).	surgical termination. Recommendation 1.6.1 says all women should be offered a choice and recommendation 1.6.2 refers to a patient decision aid that will be published alongside the guideline to help women make an informed choice.
Life	Guideline	28	23	An alarming statement is made on p28: "*Even small reductions in waiting times would result in large cost savings. A reduction of 1 day in the average waiting time would save the NHS £1.6 million per year*". One day more for a woman about to undergo a termination could make all the difference to her decision. In a crisis pregnancy scenario, time is a precious resource. It is integral to the self-actualising process that a person is allowed to process their thoughts in their own world. To calculate the cost of those 24 hours is cold and insensitive. Rushing a woman through the abortion process is dehumanising and trivialises the seriousness of her decision.	Thank you for your comment. Care has been taken throughout the guideline and in recommendations to highlight that women should not be unduly rushed into abortions. Recommendation 1.1.7 was included to ensure that women can wait longer to have an abortion if they would prefer this for whatever reason, including if she is still considering her options. Recommendation 1.1.8 has also been amended to say women should be provided with, or referred to support to make a decision if they request this. The calculation of the £1.6 million figure is discussed in detail in Evidence Report A, Appendix J including assumptions around it. The figure only includes procedure and adverse event costs and wider costs (such as societal) are explicitly not considered. However, posited cost savings are a result of recommendations, not the reason for them.
Life	Guideline	28 - 29	30, 1 - 2	It appears that one of the goals of cost-cutting is to redirect those resources into obtaining new referrals. This is mentioned on p28-29: "…*recommendations on expulsion at home and remote follow-up will minimise the number of appointments needed, so there will be greater*	Thank you for your comment. How any savings could be reinvested are not explicitly covered by this guideline. This sentence has therefore been changed to '…minimise the number of appointments needed, again leading to cost savings'. However, posited cost savings are a

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				resources available for new referrals". New referrals for new referrals sake is not in the best interest of women but fuels the conveyor belt culture amongst private abortion providers.	result of recommendations, not the reason for them.
Life	Guideline	29	15 - 17	The guidance explains that expanding the role of nurses and midwives "*should increase the number of appointments available, enable women to present earlier and contribute to cost savings*." It would seem, therefore, that the emphasis to scale back doctor involvement in the abortion process, has a cost-cutting motivation behind it. This is particularly troubling when coupled with encouragement of patients to take powerful drugs such as mifepristone and misoprostol in a non-clinical setting, such as their own home.	Thank you for your comment. Trying to enable women to present earlier is in response to: 1) evidence that morbidity and mortality rates increase for every additional week of gestation, 2) the fact that women have a greater choice regarding type of procedure at earlier gestations, and 3) evidence that decreasing waiting time was an important avenue for improving care (please see the committee discussion of the evidence in evidence report A). Further, there was evidence that satisfaction was greater with nurse or midwife led services compared with physician-led services. The committee were also aware of a Cochrane review that showed no difference in the efficacy of medical abortion or the complication rate following surgical abortion, conducted by mid-level providers (nurses, midwives and physician assistants) compared with physicians. This information is included in the discussion in evidence report A. Posited cost savings are a result of recommendations, not the reason for them.
London-Irish Abortion Rights Campaign	Guideline	General	General	**1. The London-Irish Abortion Rights Campaign has reviewed this draft NICE guideline with a focus on the degree to which the guideline makes provision for the particular challenges and obstacles faced by those women and**	Thank you for your comments. The committee were very aware of the barriers women from Northern Ireland and the Republic of Ireland face to accessing abortion care and hope that the recommendations made on self-referral, funding for travel, the use of telephone and video call

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				pregnant people who have to travel from other jurisdictions to access abortion care services in England (the default jurisdiction for application of NICE guidelines). 2. This focus reflects the purpose of our organisation which is to campaign for access to free, safe, legal abortion across the island of Ireland. We are a London-based branch of the national Abortion Rights Campaign in Ireland, and support the Northern Ireland campaigning organisation Alliance for Choice. 3. As a member of the Coalition to Repeal the Eighth Amendment and the national civil society umbrella group Together For Yes, we were proud to play our part in the successful campaign to remove the Eighth Amendment from the Irish constitution in 2018. 4. The current number of people travelling from Ireland and Northern Ireland to access abortion services in England is known to be as follows: a. Ireland i. abortion care services are now in place in Ireland, but women and pregnant people continue to travel	assessments will reduce the challenges faced by these women. However, the committee could not make recommendations specific to these women as there are many groups of women that may have differing factors or complications to accessing services, and it is not possible to make exhaustive reference to all circumstances. However, recommendation 1.2.2 has been amended to remind healthcare professionals to take account of women's preferences and needs.

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				to England to access services ii. at least 85 abortions took place in UK clinics in Jan-Feb 2019 compared with 157 for Jan-Feb 2018[179]. b. Northern Ireland i. there were only 12 lawful abortions recorded in public hospitals in Northern Ireland in 2017/18 ii. UK DHSC statistics recorded 861 abortions provided in 2017 for women who travelled from Northern Ireland[180] iii. official statistics are not available for the number of pregnant people who obtain abortion pills online for illegal use at home in Northern Ireland. In their submission to the Women and Equalities Committee Inquiry into Abortion Law in Northern Ireland, Alliance for Choice said at	

[179] https://www.independent.ie/irish-news/health/irish-women-still-travelling-to-britain-in-droves-for-abortions-37915827.html

[180] https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/1584/158405.htm#_idTextAnchor012

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				least 400 packages of safe but illegal abortion pills were sent to Northern Ireland in 2017 from one online provider.[181] 5. **Our overarching recommendation is that this draft guideline should explicitly reflect how abortion services can best provide holistic and person-centred care for all those who must travel from home to access abortion services in another jurisdiction.** 6. The fact that people travelling from the island of Ireland represent a small % of the total number of people having abortions in England and Wales means their particular circumstances can be too easily overlooked in the provision of abortion care services. This issue is of particular concern for people from marginalised groups such as those a. from lower socio-economic groups b. who are being abused or coerced by their partner c. with insecure immigration status d. without travel documentation	

[181] http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/women-and-equalities-committee/abortion-law-in-northern-ireland/written/93751.html

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				e. who are not registered with a GP. 7. This recommendation is particularly important for those travelling from Northern Ireland for the following reasons: a. they are travelling to access legal abortion services in England and returning to their home in a jurisdiction where abortion is effectively illegal b. the continued uncertainty over the legality of healthcare professionals in Northern Ireland referring residents of Northern Ireland to abortion services in England, funded by the Government Equalities Office[182] c. the implications of that uncertainty for the outcome of the Northern Ireland Department of Health's standard review process for adoption of NICE guidelines which checks "*for legal, policy and financial consequences related to its implementation in NI. As a result, the guidance may be endorsed with caveats to advise local HSC organisations of any equivalent legislation/policy or any*	

[182] https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/1584/158409.htm#_idTextAnchor039

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				specific instructions/requirements".[183]	
London-Irish Abortion Rights Campaign	Guideline	1	4	2. The draft guideline title is "Termination of Pregnancy". The phrase "termination of pregnancy" appears 229 times throughout the document (including in the footer of the 55 pages of the draft guideline) 3. In contrast, the word "abortion" is used only 7 times throughout the 55 page document a. once in the text of a footnote referencing the Abortion Act (page 5) b. four times in the text of 2 footnotes referencing abortion statistics (page 10) c. once in reference to the Abortion Act (page 29, line 8) d. once in the text of evidence review (page 53, line 4). 4. This contrasts with the language used in other recently published clinical/medical guidelines which use the word "abortion" in the title and throughout the guideline e.g.	Thank you for your comments. In response to yours and others' comments the title of the guideline has been amended to 'Abortion Care', and the term 'abortion' has replaced 'termination of pregnancy' in the recommendations.

[183] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hsc-sqsd-3-13.pdf

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				a. WHO Guideline "Medical Management of Abortion" (Jan 2019)[184] b. RCOG "Clinical Guidelines for Early Medical Abortion at Home – England" (Jan 2019).[185] **5.** We are concerned that the almost total avoidance of the word "abortion" in the draft NICE guideline will contribute to the ongoing stigmatisation of abortion provision and service users. What is the rationale for the reliance on the phrase "termination of pregnancy" in the NICE draft guideline? 6. The language used to communicate about abortion can influence how the reader absorbs/understands the information. It is essential that communicators choose language that encourages a broad understanding of the realities of abortion and does not reinforce negative stereotypes.	
London-Irish Abortion Rights Campaign	Guideline	1	5	1. The scope of the draft guideline is described on the first page as follows: *"This guideline covers termination of*	Thank you for comment. The introductory text to the guideline has been amended to clarify that this guidance is relevant for women and people who are pregnant but do not identify as women.

[184] https://www.who.int/reproductivehealth/guideline-medical-abortion-care/en/

[185] https://www.rcog.org.uk/en/guidelines-research-services/guidelines/early-medical-abortion-home-england/

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				pregnancy for women of any age." 2. Throughout the draft guideline, the language used to describe service users exclusively refers to "women". There is no acknowledgement in the current draft that abortion is a part of healthcare services that is also relevant for trans and non-binary pregnant people. Trans and non-binary people can face discrimination in all aspects of their lives, including when trying to access healthcare. 3. We recommend that the guideline makes explicit reference to the fact that abortion is a healthcare service of relevance to trans and non-binary pregnant people as well as to women and girls.	However, for simplicity of language, the term women is still used throughout the guideline.
London-Irish Abortion Rights Campaign	Guideline	4	3 - 5	Clause 1.1.1 "*Commissioners and providers should work together to make information about termination of pregnancy services (including how to access them) widely available."* 1. Ready access to accurate and clear information about abortion services is a key requirement for all service users, irrespective of their location. The guideline should recognise that the internet is a key source of information for many service users.	Thank you for your comments. As with all NICE guidance, this guideline should be read in conjunction with the NICE guideline on Patient Experience in Adult NHS Services which makes recommendations on knowing the patient as an individual and tailoring healthcare for each patient, and which is cross referenced in recommendation 1.2.5 of this guideline. Recommendation 1.2.1 was included in response to evidence that the women look on the internet for information and that this may be inaccurate. This is explained in the 'why the committee made the recommendations' section for providing information.

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				2. We recommend that the guideline requires that commissioners and providers take action to ensure that information made available or signposted to is an unbiased, recognised source of evidence-based information on abortion. It is important that this is written in simple language following the principles of health literacy good practice, and avoiding medical jargon and unintentional stigmatisation of abortion. *Evidence: See the actions which had to be taken by the Health Service Executive (HSE) of Ireland to ensure that service users were not directed to fake websites, passing off as the official Myoptions.ie website https://www.irishtimes.com/news/politics/hse-complains-to-google-over-myoptions-ie-website-1.3782115* *Evidence: The Irish doctors group START (Southern Taskgroup on Abortion and Reproductive Topics) note in their position paper: "A 24/7 telephone helpline staffed by trained personnel will be an essential service to coordinate care, arrange appointment with providers, avoid*	

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				obstructers, give reassurance or referral during TOP "[186] 3. Online misinformation has been recognised as a serious cause for concern in all areas of society[187]. The guideline should require that commissioners and providers report sources of misleading information to enable coordinated takedown responses where applicable. 4. We are concerned that the draft guideline makes no reference to the need for commissioners and providers to ensure information about abortion services is fully available to people with disabilities. *Evidence: In January 2019, the HSE in Ireland set up "My Options", a free unplanned pregnancy support service which included a national telephone number crisis pregnancy hotline. This was not fully accessible to people who are deaf or hard-of-hearing.* *In response to concerns raised by disability campaigners, it has now been announced that the HSE is expanding My Options to include a webchat facility*[188]*.*	

[186] https://startireland.ie/resources/Eimear.pptx

[187] https://www.parliament.uk/business/committees/committees-a-z/commons-select/digital-culture-media-and-sport-committee/news/fake-news-report-published-17-19/

[188] https://www.thejournal.ie/web-chat-my-options-4514222-Feb2019/

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London-Irish Abortion Rights Campaign	Guideline	4	9 - 10	Clause 1.1.2 *"Commissioners and providers should allow women to self-refer to termination of pregnancy services"* **1.** We endorse this guideline recommendation and would like it stressed that the ability to self-refer is also available to people from Northern Ireland who will have to travel to England or Wales to access abortion services. 2. The importance of self-referral is of particular importance for people in Northern Ireland where, as reported by the recent House of Commons Women & Equalities Committee report, there is continuing uncertainty about the legality of doctors in Northern Ireland referring patients to the government-funded scheme, which provides free abortions in England.[189]	Thank you for your comment. The committee agree that the option to self-refer does apply to women in Northern Ireland but felt this was too specific a point to include in the recommendation which will apply to all women accessing services across England.
London-Irish Abortion Rights Campaign	Guideline	4	11 - 12	Clause 1.1.3 "*Healthcare professionals should not allow their personal beliefs to delay access to termination of pregnancy services*." 1. We strongly endorse the guideline recommendation that healthcare	Thank you for your comments.

[189] https://www.bbc.co.uk/news/uk-northern-ireland-48044805

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				professionals' personal beliefs should not delay access to abortion services.	
London-Irish Abortion Rights Campaign	Guideline	4	15 - 16	Clause 1.1.4 *"Commissioners should consider upfront funding for travel and accommodation for women who:* *• are eligible for the NHS Healthcare Travel Costs Scheme and/or* *• need to travel to a service that is not available locally."* 1. We endorse the guideline recommendation that commissioners should consider upfront funding to remove barriers that will disproportionately affect already marginalised groups who may not have the funds available. 2. We would recommend this could be strengthened by changing 'consider' to 'offer', so it is a clear option for all those who have to travel and may need this upfront financial assistance. 3. We also suggest that information is shared with women and pregnant people about this option to avail of upfront funding in these circumstances as part of the information commissioners and providers make available, described in Clause 1.1.1.	Thank you for your comment. The committee were not able to make a stronger recommendation for upfront funding based on the evidence available. An additional point has been added to this recommendation to say that commissioners should make information about any upfront funding available. This information was not added to 1.1.1 as it does not apply to all women.

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London-Irish Abortion Rights Campaign	Guideline	5	4 - 5	Clause 1.1.8 *"Do not require women to have compulsory counselling or compulsory time for reflection before the termination of pregnancy."* 1. We strongly endorse the guideline recommendation that compulsory counselling and wait times should not be mandated for abortion service users *Evidence: The negative impact of a non-evidence-based mandatory waiting period as part of abortion service provision in Ireland has been highlighted by the Irish doctors group START*[190].	Thank you for your comments.
London-Irish Abortion Rights Campaign	Guideline	5	19 - 24	Workforce and Training Clause 1.1.13 *"For specialities that include training in termination of pregnancy as part of the core curriculum:* ● *ensure all trainees have the training, unless they opt out due to a conscientious objection* ● *include practical experience of termination of pregnancy services and procedures in the curriculum"* 1. We recommend that workforce development additionally includes values clarification training to help ensure that	Thank you for your comment. Whilst the guideline makes recommendations about the principles under which training should be delivered, the specific content of training is beyond the scope of NICE guidelines.

[190] https://startireland.ie/resources/draft%20final.%20statement%20from%20START%20conference%207.pdf

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				services are supportive and non-judgemental. *Evidence: Royal College of Physicians of Ireland - Institute of Obstetrics and Gynaecologists,* *Interim Clinical Guidance (Dec 2018), Section 11*[191] *:* *"From a holistic perspective, training should also address the following:* *• Non-directive information and support for women seeking abortion care* *• Contraceptive provision* *• Participation in values clarification exercises to enable providers differentiate their own personal beliefs and attitudes from the needs of women seeking termination of pregnancy* *• Wellbeing / supporting the carer / vicarious trauma / emotional fatigue"*	
London-Irish Abortion Rights Campaign	Guideline	6	5 - 11	Complex comorbidities Clause 1.1.15 "*Commissioners should ensure that specialist centres are available as locally as possible, to reduce delays and travel times for women with complex needs or significant comorbidities."*	Thank you for your comments. On reflection, as the specification and commissioning framework for specialist abortion services is currently being developed by NHS England, we have amended 'commissioners should ensure specialist centres…' to 'specialist centres should…' to make a distinction between the commissioning

[191] https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2018/12/FINAL-INTERIM-CLINICAL-GUIDANCE-TOP-12WEEKS.pdf

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				Clause 1.1.16 "*Providers should develop pathways for women with complex needs or significant comorbidities to:* ● *refer them to specialist centres if needed* ● *minimise delays in accessing care* ● *avoid the need for women to repeat key steps (such as returning to their GP for referral, or repeated assessments or investigations)."* **1.** We endorse both of these recommendations. 2. In addition, we would highlight that due to the lack of services in Northern Ireland, people with complex comorbidities are likely to experience delays in accessing care. Travel itself will be more difficult for this patient population.	framework for this recommendation and other references to commissioners within this guideline.
London-Irish Abortion Rights Campaign	Guideline	6	7 - 11	Clause 1.1.9 "*Consider providing termination of pregnancy consultations by phone or video call, for women who prefer this."* Clause 1.1.10 "*Consider providing termination of pregnancy services in a range of settings (including in the community and in hospitals), according to the needs of the local population."* 1. We strongly endorse these recommendations.	Thank you for your comments. Recommendation 1.1.9 makes it clear that whether remote or in face consultations are used should be based on women's preferences. The committee discussion in evidence report A contains additional information about the importance of patient choice.

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				Evidence: Research undertaken by Dr. Abigail Aiken and colleagues in 2017[192] found that women and pregnant people in Great Britain experienced a multitude of barriers in accessing abortion in clinic settings (for example, childcare commitments, distance from clinics and long waiting times). Providing abortion in a wider range of settings (Clause 1.1.10) and via phone or video call (Clause 1.1.9) would increase the accessibility of services and enable a greater degree of patient autonomy. 2. For Clause 1.1.9, the ability to provide initial consultations by telephone/video call would be particularly beneficial to those living in Northern Ireland whose abortions are taking place in England. Having a phone or video consultation would reduce the length of time for which people would need to be away from home. 3. In order for services to be truly patient-centred, the choice of location and whether to opt for a remote or in-person consultation must be in the hands of the woman or pregnant person.	

[192] https://www.contraceptionjournal.org/article/S0010-7824(17)30435-3/fulltext

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London-Irish Abortion Rights Campaign	Guideline	6	15 - 20	Avoiding stigma Clause 1.1.17 *"When caring for women who are having a termination of pregnancy, be aware of:* ● *the anxiety they may have about perceived negative and judgemental attitudes from healthcare professionals* ● *the impact that verbal and non-verbal communication may have on them"*. 1. We strongly endorse this recommendation. 2. As noted above in relation to Workforce Training clause 1.1.13, we recommend the provision of values clarification training for healthcare professionals and all staff involved in service provision to help ensure that services are supportive and non-judgemental. 3. We are concerned that the draft guideline makes no reference to the need to manage the impact on service users and healthcare providers of actual (not perceived) "*negative and judgemental attitudes*" when anti-abortion protestors are active outside abortion service facilities. *Evidence: The Royal College of*	Thank you for your comment. It is beyond the scope of this guideline to address the content of training or how to manage the issue of protestors.

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				Obstetricians and Gynaecologists and The Faculty of Sexual and Reproductive Healthcare Submission to the Home Office Abortion Clinic Protest Review (March 2018)[193] highlighted the following effects of protests beyond the experience of harassment and intimidation: ● *"In some cases, women are so put off that they end up deferring their treatment (the higher the gestation at which an abortion is carried out, the greater the risk of complications and death).* ● *We have also heard of cases of women opting for simultaneous administration of their drugs for a medical abortion to avoid a repeat consultation, which is known to have a lower efficacy than leaving an interval of 6 – 48 hours between taking the two medicines.* *Thirdly, women have resorted to an abortion using drugs obtained from the internet rather than face the protestors so that they can access professional services"*	

[193] https://www.fsrh.org/documents/rcog-fsrh-submission-home-office-review-protests-abortion-clinic/

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London-Irish Abortion Rights Campaign	Guideline	7	5 - 12	Clause 1.2.2 *"Provide information about the benefits and risks of medical and surgical termination of pregnancy (see table 1).* *Do this without being directive, so that women can make their own choice.* *Table 1: Factors influencing a woman's decision between medical and surgical termination of pregnancy* *Medical and surgical termination of pregnancy are both highly effective and safe.* *The effectiveness and safety of both methods is similar, so if both are suitable the method used will depend on the woman's preference."* 1. We support the non-directive nature of this guidance on the benefits and risks of the different procedures. 2. However, we are concerned that the draft text does not acknowledge the degree to which a woman's choice may in practice be limited by the need to travel back to the island of Ireland as soon as possible after the procedure. *Evidence: BPAS has specific webpages for people travelling from the island of Ireland. These are good examples of how travel considerations should be explicitly signposted in the descriptions of the*	Thank you for your comments. The committee were very aware of the barriers women from Northern Ireland and the Republic of Ireland face to accessing abortion care and hope that the recommendations made on self-referral, funding for travel, the use of telephone and video call assessments will reduce the challenges faced by these women. However, the committee could not make recommendations specific to these women as there are many groups of women that may have differing factors or complications to accessing services, and it is not possible to make exhaustive reference to all circumstances.

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				procedures available to a service user: ○ *https://www.bpas.ie/travelling-to-bpas/ Information on travelling to BPAS from Irish airports: It is best to wait 24 hours before travelling home after your treatment. If you must travel just make sure you know how to access emergency services at your destination in case of a complication. Please be aware if you are having the abortion pill up to 10 weeks and choose to travel soon after taking the second medication (misoprostol) that you may start to have cramps and bleed heavily whilst travelling.* *https://www.bpas.ie/abortion-treatments/* *The abortion pill - up to 10 weeks of pregnancy...We recommend that you do not travel until the pregnancy has passed (90% of women will pass the pregnancy within 4 hours of taking the 2nd medication).* *Surgical methods are a practical option for women needing to travel for treatment and most treatments (up to 20 weeks) need only one visit to the clinic.* *If you are travelling from Ireland we will try and arrange for your consultation and treatment on the same day - plan to be at the clinic for the whole*	

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				day.	
London-Irish Abortion Rights Campaign	Guideline	8 17	 13	Table 1 Row 2: *Factors influencing a woman's decision between medical and surgical termination of pregnancy* *Surgical Procedure; Between 14+0 weeks and 23+6 weeks* Clause 1.11 *Medical termination after 23 +6 weeks* 1. We note that the Page 8 Table outlines the factors relevant to a surgical abortion is headed by the gestational period "*Between 14+0 weeks and 23+6 weeks"*, while Page 17 includes a section on medical termination after 23+6 weeks. What is the rationale for excluding any specific reference in the table to the gestational period after 23+6 weeks?	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. This PDA is intended to assist in decision making where there is a choice between medical and surgical termination of pregnancy. All terminations in England and Wales after 23+6 weeks are medical terminations; therefore, a choice between methods is not available. For this reason, the PDA does not cover termination of pregnancy from 24 weeks. This was agreed at the scoping stage. However, there would still be a full discussion with women about what a termination of pregnancy at this gestational age will involve, in line with good clinical practice and recommendations in section 1.2.
London-Irish Abortion Rights Campaign	Guideline	12 12	16 - 17 18 - 25	Clause 1.2.10 *Provide women with information about the different options for handling fetal remains* Information for women who are having a termination because of fetal anomaly 1. We are concerned that the draft guidance insufficiently acknowledges the particularly traumatic experience of people travelling from the island of Ireland	Thank you for your comment. The Human Tissue Authority has guidance on the right to take remains home. This information has been added to the rationale but it is beyond the scope of this guideline to provide specific guidance on this.

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				following the diagnosis of a fatal fetal anomaly. *Evidence:* 2017 JUDGMENT In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland) Reference by the Court of Appeal in Northern Ireland pursuant to Paragraph 33 of Schedule 10 to the Northern Ireland Act 1998 (Abortion) (Northern Ireland)*: "Travelling to Great Britain is even more difficult in such cases, as the problem is often detected comparatively late in the pregnancy, at 18 to 20 weeks, which leaves very little time to make the arrangements and there may be no counselling offered on what the options are. If the woman does manage to travel, not only will she have all the trauma and expense associated with that, but also serious problems in arranging the repatriation of the foetal remains."*[194] *Evidence: 2019 Report of the Women and Equalities Committee* - abortion service users may "*need to make decisions about the remains of the foetus or unborn child but are not provided with the information they need, particularly where they have*	

[194] https://www.supremecourt.uk/cases/docs/uksc-2017-0131-judgment.pdf

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				travelled outside of Northern Ireland to access an abortion. The remains may be wanted so that the parents can give the foetus or unborn child a funeral or for the purposes of medical testing where there has been a foetal abnormality. In the case of victims and survivors of rape and incest, the remains may be required as evidence in any criminal proceedings".[195] We recommend that the NICE guideline incorporates this recommendation from the Women and Equalities Committee report: "*There should be specific information provided to women and girls about their rights to bring home the remains of the foetus or unborn child for personal reasons or for medical purposes or in the event of criminal proceedings."*[196]	
London-Irish Abortion Rights Campaign	Guideline	16	3 - 7	Expulsion at home for medical termination before 10+1 weeks Clause 1.8.1 "*Offer the option of expulsion at home to women who are having a medical termination of pregnancy if they will be taking the mifepristone before 10+1 weeks' gestation*." 1. We endorse this recommendation but request clarity on how this would apply to	Thank you for your comment. The recommendations have been amended to clarify that women up to 9+6 weeks gestation can take the misoprostol at home (or in clinic/hospital) and expel the pregnancy at home but women at 10+0 will have to take the misoprostol in clinic before expelling the pregnancy at home. The options of home expulsion, taking misoprostol at home after an interval of 24-48 hours, and of self-assessment/remote follow-up introduce more

[195] https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/1584/158409.htm#_idTextAnchor039

[196] Clause 116 https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/1584/158409.htm#_idTextAnchor039

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				people to have to travel in order to access services not available to them locally. For example, people living in Northern Ireland, Ireland and rural parts of Britain.	flexibility in abortion care that should make it easier for women who have to travel to access services.
London-Irish Abortion Rights Campaign	Guideline	19	General 21 - 22	Anaesthesia and sedation for surgical termination *1.13.1 Consider general anaesthesia,deep sedation, conscious sedation with local anaesthesia,or local anaesthesia alone for women who are having surgical termination of pregnancy. To help women make an informed choice, discuss the options with them and explain that:* *•having local anaesthesia alone means they will be able to spend less time in hospital* *•intravenous sedation plus local anaesthesia will help if they are anxious about the procedure* 1. We recommend that the guideline ensures the impact each choice of sedation will have on how long a person will potentially need to spend in hospital is shared with the person before they make a decision. This is a material consideration for those travelling to access services who may need to travel home to another jurisdiction as soon as possible after the procedure.	Thank you for your comment. A patient decision aid will be published alongside the guideline which contains information about the effect of different methods of anaesthesia and sedation on how long women will need to remain in the service and whether they need someone to accompany them home. However, it was not possible to state how long women will have to wait based on the type of anaesthesia or sedation used as this may be affected by other factors.
London-Irish Abortion Rights Campaign	Guideline	20	General 16	Clause 1.14 "*Follow-up and support after a termination"*	Thank you for your comment. Recommendation 1.2.10 recommends to "Provide women with information about the different options for management and disposal of pregnancy remains".

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				1. We are concerned that this section makes no reference to the particular circumstances of people who have had to travel from the island of Ireland for an abortion following a diagnosis of severe or fatal foetal anomaly, and who may need information to inform decisions about fetal remains. 2. As noted in the recent report of the Women and Equalities Committee, abortion service users may "*need to make decisions about the remains of the foetus or unborn child but are not provided with the information they need, particularly where they have travelled outside of Northern Ireland to access an abortion. The remains may be wanted so that the parents can give the foetus or unborn child a funeral or for the purposes of medical testing where there has been a foetal abnormality. In the case of victims and survivors of rape and incest, the remains may be required as evidence in any criminal proceedings*".[197] **3.** We recommend that the NICE guideline incorporates this recommendation from the Women and Equalities Committee report: "*There should be specific*	The Human Tissue Authority has guidance relating to the disposal of the pregnancy remains, including the right to take remains home. This information has been added to the rationale but it is beyond the scope of this guideline to provide specific guidance on this. As with all NICE guidance, this guideline should be read in conjunction with the NICE guideline on Patient Experience in Adult NHS Services which makes recommendations on exploring the patient's preferences about the level and type of information they want.

[197] https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/1584/158409.htm#_idTextAnchor039

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				information provided to women and girls about their rights to bring home the remains of the foetus or unborn child for personal reasons or for medical purposes or in the event of criminal proceedings."[198] 4. The guideline should also reflect the fact that some service users may not wish to know about these options.	
London-Irish Abortion Rights Campaign	Guideline	20	17 - 21	Clause 1.14.3 *"Explain to women* ● *what aftercare and follow-up to expect* ● *what to do if they have any problems after the termination of pregnancy, including how to get help out of hours* ● *that it is common to feel a range of emotions after the termination."* 1. We recommend that this section on follow-up and support makes reference to advising service users when they can resume normal activities, including sexual intercourse.	Thank you for your comment. Details of how soon women can return to normal activities is included in a patient decision aid that will be published at the same time as the guideline.
London-Irish Abortion Rights Campaign	Guideline	24 - 25		1 Service organisation 2 Why the committee made the recommendations *Making it easier to access services*	Thank you for your comment. The evidence you cite discusses the impact of the abortion law in Northern Ireland and includes information about women who have self-referred and the difficulties associated with this but does not provide details of

[198] Clause 116 https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/1584/158409.htm#_idTextAnchor039

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			18 - 2	*"With this in mind, the committee recommended that services enable women to self-refer. This will improve women's experiences and could also help them avoid stigma and negative attitudes when requesting a termination of pregnancy. There was no evidence on the best way to enable self-referral (for example through dedicated booking systems, centralised referral, drop-in services, or online booking), so the committee could not make a more specific recommendation.* *There was evidence that travel costs can be a significant barrier to accessing services. This may be a particular problem for women with low incomes and women who need to travel for a service that is not available locally. Women having a termination of pregnancy often have to travel at very short notice and may have difficulty arranging funds before the appointment".* **1.** Barriers to abortion service access inform many aspects of our response to this draft consultation. These are reflected in multiple parliamentary committee reports, peer-reviewed publications, court rulings, news coverage and the lived experiences of over 200,000 women and pregnant people who are known to have travelled from the island of Ireland to Britain for an abortion since 1983.	specific methods for self-referral that could inform recommendations in this area. Recommendation 1.1.4 should help improve access to abortion services for women who would find it difficult to afford travel and accommodation

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				2. In the absence of formal evidence on the most effective ways to enable a self-referral, we recommend that consideration is given to the themes highlighted in the many recent documented accounts of those who have had to travel from the island of Ireland to Britain for an abortion. *Evidence: Women and Equalities Committee, Oral evidence: Abortion Law in Northern Ireland, HC 1584 (ii)(private session), Thursday 24 January 2019 Derry / Londonderry - Witness A, Witness B, Witness C, and Witness D*[199]. 3. Travel costs have always been a significant barrier to abortion service access. We supported the launch in June 2017 by Westminster to make provision for travel costs in cases of financial hardship to enable women who would not otherwise have afforded it to access the funded services in England.	
London-Irish Abortion Rights Campaign	Guideline	55	3 - 12	Context *"However, there is marked variation across the country, involving different types of providers and, increasingly, organisations outside the NHS. In addition, accessing termination of pregnancy*	Thank you for your comment, the context section has been amended to acknowledge the challenges that women from Northern Ireland face when accessing abortion services.

[199] http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/women-and-equalities-committee/abortion-law-in-northern-ireland/oral/99571.html

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				services may be difficult for women who live in remote areas, who are in the second trimester of pregnancy, or who have complex pre-existing conditions or difficult social circumstances. This guideline will help ensure that termination procedures are carried out based on 10the best available evidence, and that a choice of services is easily accessible to all women who request a termination of pregnancy." 1. We recommend this section of the guideline include an explicit reference to the lack of abortion services in Northern Ireland, as we feel 'marked variation' does not go far enough in explaining the differences across the UK. It should also reference the fact that this means travel to England or Wales is unavoidable for those in Northern Ireland who do not procure safe but illegal abortion pills online for self-administration at home.	
Marie Stopes UK	Guideline	General	General	The guidance appears to be orientated towards NHS provision, and does not accurately consider the unavoidable financial and contractual pressures faced specifically by independent sector providers in England, who are funded to provide and deliver abortion services at a rate considerably below NHS tariff.	Thank you for your comment. NICE guidelines are written for NHS services, although they are also relevant for the range of independent sector providers who are funded by the NHS to deliver services in this area. It is, however outside the scope of this document to comment on the tariffs in place.

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Marie Stopes UK	Guideline	General	General	The decriminalisation of abortion would reduce the need for medical input into uncomplicated early medical abortion, and enhance career development opportunities for nursing and paramedical staff. It would also work towards destigmatising abortion care to help providers to recruit and retain team members.	Thank you for your comments. The legal status of abortion is outside the scope of this guidance, and of NICE's remit.
Marie Stopes UK	Guideline	4	3 - 8	Marie Stopes UK would welcome further support from commissioners to facilitate prompt onward referral. Ideally, this referral would be to a local service, but if this is not possible, to the nearest feasible location that provides appropriate treatment. Where there is no local NHS provision, CCGs can be inflexible. In addition, we find that some commissioners do not give full support to facilitating local onward referral. Often clients are unable to travel, and we feel commissioners should place more pressure on local services to accept clients in such circumstances. The fragmentation of commissioning, nationally, for abortion services is unhelpful as it sets up local and regional decision-making which does not necessarily look at the wider picture and is not necessarily in the best interests of women's reproductive health and services. This fragmentation can lead to	Thank you for your comment. The commissioning structure is beyond the scope of NICE's remits, however the recommendations about service organisation in this guideline (1.1.1, 1.1.5, 1.1.10, 1.2.11) should help to ensure that commissioners do facilitate onward referral.

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				reduced choice in provision for women and create a working environment that does not always support prompt onward referrals, especially where there is no local option available.	
Marie Stopes UK	Guideline	4	13 - 16	Marie Stopes UK would welcome commissioners providing upfront funding for travel and accommodation for women who are eligible for the NHS Healthcare Travel Costs Scheme and/or need to travel to a service not in their locality. Although there is currently funding available to repay the costs of travel for necessary treatment, many vulnerable and marginalised clients may not meet the criteria for this funding. If they do meet the criteria, they may not have the available funding to pay the costs upfront, in order to claim back at a later date. However, it is unclear from the guidance how upfront funding would work in practice, and what the criteria would be for this funding. If NHS provision was expanded locally, the need for clients to travel out of area for treatment and incur the associated costs would be reduced significantly.	Thank you for your comment. There is already eligibility criteria for the NHS Healthcare Travel Costs Scheme. It was not possible to make more detailed recommendations about eligibility for upfront funding or those who do not meet these criteria but need to travel to access services. Therefore, these criteria would need to be locally determined. Recommendation 1.1.10 should expand local provision of services. However, it is not feasible for all services to offer all options or to be available every day.
Marie Stopes UK	Guideline	4	21 - 24	Please can the guidelines clarify if these figures relate to working days, rather than a 7-day week.	Thank you for your comment. One week refers to one calendar week, not working days. It would be difficult to specify working days due to variation in the number of days services are available for

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				In order for waiting time targets to be realistic, there is a need to consider avoidable factors only. Marie Stopes UK recognises that waiting times need to be reduced at all gestations, and has worked hard over the last 18 months to achieve considerable reductions, including being able to provide next-day appointments for EMA in many of our centres. We already undertake telephone assessment, but the clinical pathway is more complex than referral - assessment – treatment, as risk assessment needs to be robust and, for those undergoing surgical abortion, further pre-treatment assessment is required to provide a safe, high quality service. For clients who present very early in their pregnancy, before intra uterine pregnancy can be confirmed, a referral to treatment interval of two weeks is not feasible unless the service provision model is altered to remove the need to confirm intra-uterine pregnancy for all clients. Although we support the careful introduction of very early abortion (see comment 20 on guideline 1.7), this will require serological tests and close follow up, introduces additional costs and may not be suitable for all clients. For clients who present at later gestations (19 weeks and above) these targets are also challenging due to the paucity of specialist abortion provision above this gestation.	different providers. The waiting times set out in this guideline are an ideal that would minimise delays, however, the committee agree that this may not always be possible and that safety is paramount, with each patient needing to be assessed to identify what is clinically most appropriate. Recommendation 1.1.7 was included to ensure women can wait longer for an abortion if they would prefer this.

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				Waiting times for individual clients can also be extended due to factors beyond the control of the service provider. Client choice is paramount, and it is often the case that clients themselves fail to progress their referral for various reasons, leading to perceived delay in service provision. The failure of the UK Government to introduce national buffer zones around abortion clinics means that clients may be deterred from entering premises on their appointment day due to a strong protest presence involving harassing and intimidating activity, leading to appointments needing to be rebooked for the client.	
Marie Stopes UK	Guideline	5	4 - 5	We agree that services should not require women to have compulsory counselling or reflection time before termination of pregnancy. Our view is that there are certain circumstances in which counselling before termination of pregnancy should be encouraged (but not compulsory) if, after careful multidisciplinary team assessment, it is considered to be in the 'best interests' of the client. For example, an assessment based on mental capacity concerns. At Marie Stopes UK, we aim to develop services based on the mental capacity, rather than the age, of clients. Marie Stopes UK does not support compulsory reflection time, but fully supports any client who needs further reflection before making decisions around their care.	Thank you for your comment. Recommendation 1.1.8 has been amended to say women should be provided with, or referred to support to make a decision if they request this. The introductory text has been amended to remind healthcare professionals to provide information and obtain informed consent in line with General Medical Council guidance (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent), which provides guidance about capacity. Further, recommendation 1.1.7 was included to ensure women can wait longer for an abortion if they would prefer this.

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Marie Stopes UK	Guideline	5	9 - 11	We fully agree with this recommendation, but the provision of services in a range of settings is only feasible for EMA and 1st trimester surgical abortion. It is inherently impractical for second stage surgical abortion, and becomes even less feasible at/above 22 weeks' gestation where there are < 2000 procedures per year performed nationwide. This means that provision of surgical abortion post 22-week gestation should be consolidated nationally across fewer surgical centres for patient safety and service quality and efficiency. The current NHS England specialised commissioning proposal is for the development of 5 specialist centres, which are not geographically distributed evenly across England and therefore will not provide equitable access to specialist care.	Thank you for your comment. The committee discussion in evidence report A explains that community settings may not be suitable for all women. Recommendation 1.1.1 covers if a service cannot provide an abortion after a specific gestational age or by the women's preferred method. If there are concerns about complex comorbidities, clinicians should follow recommendations 1.1.15 and 1.1.16 and the service specification that is currently being developed by NHS England.
Marie Stopes UK	Guideline	5	13 - 14	We agree that providers should maximise the role of nurses and midwives in providing care, and this is very much part of the Marie Stopes UK model. We also strongly advocate for the decriminalisation of abortion to reduce stigma and enable enhanced roles for nurses, midwives and Allied Health Professionals to be more widely developed and introduced.	Thank you for your comments. The legal status of abortion is outside the scope of this guidance, and of NICE's remit.
Marie Stopes UK	Guideline	5	15 - 18	We agree that trainee healthcare professionals who may care for women who request termination	Thank you for your comments.

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				of pregnancy should have the chance to gain experience in termination of pregnancy services during their training. We have always been interested in providing training to nurses, midwives, medical students and doctors and actively pursue all opportunities to do so. Indemnity has previously been a barrier to training taking place outside NHS settings, but with improved indemnity arrangements for NHS commissioned care, we expect collaboration to improve.	
Marie Stopes UK	Guideline	6	8 - 13	We would like the guidelines to clarify what is meant by specialist centres. We have interpreted this as relating to later gestation and/or complex comorbidity at any gestation. We agree that providers should develop pathways for women with complex needs or significant comorbidities to be able to refer where needed, minimise delays in accessing care, and avoiding the needs to repeat key steps in their treatment journey. We perform 65,000 – 70,000 abortions per year, from clients who either self-refer or are referred from primary/community care. It is estimated that approximately 15% of these clients have factors that require additional care and attention in their treatment pathway. To address this need and to ensure all clients are managed promptly and effectively in the correct healthcare setting, we	Thank you for your comment. A service specification for specialist centres is currently being developed by NHS England and will include details of these services and indications for referral to such centres. Therefore, it was not possible to provide more information about this in this guideline. The committee discussion in evidence report A has been expanded to explain that this is why the committee did not define the requirements of specialist services.

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				have already introduced our own 'Marie Stopes UK Right Care' programme, which aims to ensure all clients are treated in the right place, at the right time, first time. For women to avoid unnecessary repetition in pre-abortion investigation, commissioners should fund the additional cost (training and laboratory testing) for these investigations to be performed in the Independent Healthcare Provider setting.	
Marie Stopes UK	Guideline	6	21 - 24	We support the need for sensitivity to the concerns around confidentiality at all times in abortion service provision, including where the client does not wish to receive personal correspondences, and/or for their GP to be contacted about their care. However, the guidance does not address the provision of STI testing, which is frequently commissioned alongside the abortion service. Clients who attend abortion services are found to be at higher risk of STI and STI testing is therefore a routine aspect of the abortion care pathway at Marie Stopes UK. Confidentiality around test results can be ethically challenging where a client has tested positive for chlamydia and does not wish her GP to be informed of her attendance at our clinic. Our Caldicott Guardian has recently reviewed this situation and concluded that the current legislation is unclear as to whether or not untreated chlamydial infection in the community	Thank you for your comment. It is beyond the scope of this guideline to review legislation.

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				constitutes a situation where confidentiality can be over-ridden. There is a need to review the legislative basis of protection of confidentiality and public interest and provide clearer guidance in SRH and abortion care settings.	
Marie Stopes UK	Guideline	8		**Table 1** In reference to Table 1: The need to be accompanied home following sedation or general anaesthetic. We strongly recommend that clients should be accompanied home following sedation or general anaesthetic, but do not 'require' this unilaterally, as this can be disadvantageous to some more vulnerable clients, including those in coercive or abusive relationships and/or who have travelled from Northern Ireland and other countries where abortion is highly restricted. Ultimately, clinical judgment is called for. After a very short general anaesthetic it may be acceptable for a client to leave the clinic unaccompanied, and we would prefer the use of 'may need someone to accompany her' rather than 'will need' in this part of the guidance. If it were to be a unilateral requirement for the client to be accompanied home, this could introduce avoidable delay to her treatment if she were to attend unaccompanied. This could increase pressure on the NHS is the client was	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The text that will appear in the PDA has been amended in line with your suggestion.

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				assessed as not able to proceed due only to their being unaccompanied.	
Marie Stopes UK	Guideline	8		**Table 1** In reference to Table 1: Surgical abortion before 14 weeks' gestations. At Marie Stopes UK, the administration of misoprostol in surgical abortion before 14 weeks is currently a matter of individual clinical assessment. For this to become routine practice would increase the immediate cost of surgical abortion and therefore should be reflected in the agreed contracted rate with CCGs.	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. There was good evidence that cervical priming reduced the risk of incomplete abortion and the force needed to dilate the cervix for women having an abortion before 14 weeks. Therefore, the committee agreed it was appropriate to offer cervical priming to all women. It is beyond the remit of NICE guidance to comment on CCG contracts, however the recommendations should highlight the importance of appropriate funding to support these recommendations.
Marie Stopes UK	Guideline	8 - 9		**Table 1** In reference to Table 1: Alternative to osmotic dilators – mifepristone or misoprostol. This practice will increase the likelihood of premature delivery and may cause undue distress to women and place increased pressure on local NHS maternity services. In addition, the use of mifepristone and/or misoprostol for cervical preparation introduces additional costs which would need to be reflected in the agreed contracted rate with CCGs. Misoprostol is a difficult drug to manufacture and at times there are significant supply-chain issues, so recommendations to increase its routine use nationally should be made with caution.	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. Recommendation 1.12.8 states that misoprostol should not be given in combination with osmotic dilators due to the risk of preoperative expulsion. However, there was no evidence for an increased risk of this with a combination of osmotic dilators and mifepristone, which may have a benefit at increased gestational ages, or with mifepristone or misoprostol alone compared with osmotic dilators. It is beyond the remit of NICE guidance to comment on CCG contracts, however the recommendations should highlight the importance of appropriate funding to support these recommendations. The recommendations include

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					alternatives to misoprostol that could be used if misoprostol was not available.
Marie Stopes UK	Guideline	9		**Table 1** In reference to Table 1: "special type of pregnancy test" The guidelines should be more explicit here, does this refer to low sensitivity pregnancy tests?	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists. The PDA does not go into this detail about the pregnancy test since this is a patient facing document.
Marie Stopes UK	Guideline	12	5 - 6	We feel that section 1.2.6 is a missed opportunity to provide more assertive guidance on contraception consultation and the provision of LARC within termination of pregnancy services.	Thank you for your comment. The committee agreed that it would not be appropriate to provide all women with information about contraception, particularly in the context of women having an abortion for fetal anomaly. There was also evidence that women thought the way information about contraception had been delivered was too 'pushy'. Recommendations 1.15.1 to 1.15.5 provide further information about providing access to contraception and timing of LARC methods.
Marie Stopes UK	Guideline	12	19 - 23	Marie Stopes UK does not provide late medical abortion, so our comments on this recommendation relate solely to the provision of surgical abortion for women having a termination because of fetal anomaly. Where possible, clients with fetal anomaly should be cared for in the NHS, and where this is not possible, close communication should be a requirement between NHS and Independent Healthcare Provider settings. We feel that it is inherently unfair to women that a surgical abortion service is not always provided by the NHS for	Thank you for your comment. Recommendation 1.12.11 has been amended to include referral when women cannot have their preferred method in the maternity service. Recommendation 1.12.11 should improve links between services.

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				these women. We will always treat clients with a diagnosis of fetal anomaly with compassion and respect, and our approach is to treat these clients no differently from others. Termination of pregnancy because of fetal anomaly is a sensitive requirement which presents a range of practical difficulties in our independent provider setting: • Environment and facilities: Our clinics do not have the space to accommodate a companion with the client throughout treatment and we cannot, in all of our centres, provide private rooms necessary for privacy and dignity for clients with fetal anomaly. • Resources: Only a very small number of our clients present with fetal anomaly. Specialist team member training in fetal anomaly would be required in all our centres to provide a high-quality service for termination of pregnancy due to foetal anomaly. • NHS connectivity: If clients with fetal anomaly are to be managed in the independent sector, then their overall care should remain with the NHS, so that appropriate information and future management can be provided systematically and seamlessly. Alternatively, NHS and Independent	

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				Healthcare Providers could form closer links, for example, through improved pathways into NHS bereavement services.	
Marie Stopes UK	Guideline	13	1 - 8	Since the publication of the NICE guidance an important research study has been published in 'Contraception' which supported the Dutch policy of not treating Rh-negative women having induced abortions under 7 weeks' gestation. We strongly support these recommendations. Provision of anti-D at early gestations is physiologically unnecessary and constitutes unnecessary overtreatment. Anti-D is frequently in short supply and its use should be prioritised for those women who need it most, and for those who are identified as rhesus D negative at later gestations.	Thank you for your comment. The results of the study mentioned are reassuring and in line with the recommendations made by the committee. This study does not meet the inclusion criteria for the anti-D review (because the population is mixed with no subgroup results presented for women having induced abortions).
Marie Stopes UK	Guideline	13	14 - 18	We support and welcome the recommendation to only give antibiotic prophylaxis to women who are having a medical termination of pregnancy if they are clinically risk assessed as at increased risk of STI. It would be useful to point guideline users towards relevant BASHH guidance on sexual history taking to complete this assessment. This recommendation is in line with our current practice, as an important contributor to effective healthcare and reducing antimicrobial resistance. However, we have found that some CCGs are currently not in support of this approach.	Thank you for your comment. In response to stakeholder comments, the recommendations for antibiotic prophylaxis for medical abortion have been amended to say they should not be routinely given rather than given to those at risk of STIs as evidence on STI risk was not reviewed as part of this guideline so this population could not be defined. However, the committee agreed that prophylaxis may be appropriate for high risk women or those who would find it difficult to access treatment at a later date in response to a positive screen for sexually transmitted infections.

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					The committee discussion in evidence report D and the rationale and impact has been updated to reflect these changes. However, a cross-reference to NICE PH3 has now been included which covers guidance on interventions to prevent sexually transmitted infections. PH3 is currently being updated.
Marie Stopes UK	Guideline	14	21 - 23	We support the pharmacological thromboprophylaxis recommendation, which is in line with our current practice. However, in the Independent Healthcare Provider setting this also needs GP and community support. Marie Stopes UK's Drug Safety Officer has highlighted that there are some safety concerns with some of the newer thromboprophylactics, and recommends that the guidance provides greater clarity.	Thank you for your comment. As no evidence was identified for this review question, the committee recommended the regimens used in the NICE guidance on hospital-acquired VTE. Therefore, it is not possible to provide any further detail regarding this.
Marie Stopes UK	Guideline	15	1 - 3	Any woman at high risk of thrombosis should be managed within the NHS setting, rather than in an Independent Healthcare Provider (IHP) clinic. In all other cases, a careful VTE assessment would be required and a 'shared care' model agreed between the IHP and the client's primary care provider. At Marie Stopes UK, this is managed through our Right Care team.	Thank you for your comment. Where there are concerns about comorbidities, clinicians should refer to recommendations 1.1.15 and 1.1.16 on complex comorbidities and the service specification that is being developed by NHS England.
Marie Stopes UK	Guideline	15	10 - 12	We support this service development of providing termination of pregnancy before there is a definitive ultrasound evidence of an intrauterine pregnancy – where there are no signs or	Thank you for your comment. Although there is a potential for overtreatment, the committee agreed that the recommendation would result in a net gain, both in terms of care for the women

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				symptoms of an ectopic pregnancy - as it would reduce waiting times for clients who present very early in pregnancy. However, it should be noted that a significant % of these very early pregnancies will abort spontaneously so this could lead to unnecessary over-treatment. In the Independent Healthcare Provider setting there may be challenges in the monitoring of serum b-HCG, since this would introduce significant practical and financial challenges to a model that is already commissioned considerably below the NHS tariff rate.	(because women will have an increased choice by having the option of an abortion before there is ultrasound evidence of an intrauterine pregnancy or delay treatment, if preferred) and in resource use, which has already been outlined in some detail in the cost effectiveness and resource use section of the committee's discussion of the evidence in Evidence report F.
Marie Stopes UK	Guideline	15	13 - 21	Women who are offered very early termination of pregnancy should be carefully assessed as to their suitability in order to ensure that they fully understand and can comply with the need for close follow up arrangements.	Thank you for your comment. Clinicians should follow professional guidance (e.g., General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent) about capacity and informed consent. However, as with the other recommendations and NICE guidelines, this is guidance only and does not override clinical judgement. Therefore, it is up to the clinician to assess whether recommendations are appropriate for a given patient.
Marie Stopes UK	Guideline	16	12 - 20	At Marie Stopes UK we offer simultaneous mifepristone and misoprostol to 9+0 and this is very popular with clients. The uptake of this regime may reduce with the new implementation of misoprostol at home. Recent research (as yet unpublished) conducted within Marie Stopes UK shows a statistically	Thank you for your comment.

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				significant incremental increase in failure rate in EMA for each week of gestation, and we support the recommendation that the use of a simultaneous regime in EMA be restricted to 9 weeks and below.	
Marie Stopes UK	Guideline	18	6 - 15	Within Marie Stopes UK, priming is currently only routinely offered to clients above 12 weeks gestation, and to others (e.g. young and/or nulliparous clients) on clinical grounds. Our complication rates are well below the international average so this is clearly not immediately unsafe. However, longitudinal studies linking this practice to complications in pregnancy in later life are lacking. We feel that the guidelines should not be prescriptive for priming in surgical abortion daycare, and that clinical judgment is required. For example, we suggest that the wording in guidelines 1.12.1 and 1.12.3 could be altered to align with that in 1.12.7, to "consider" rather than to "offer". To offer cervical priming routinely to all clients undergoing surgical abortion below 12 weeks would carry significant cost, efficiency and logistical challenges in the Independent Healthcare Provider (IHP) setting. Universal use of mifepristone and/or misoprostol for cervical priming prior to all surgical abortion will significantly increase the cost of provision and this	Thank you for your comment. There was good evidence that cervical priming reduced the risk of incomplete abortion and the force needed to dilate the cervix for women having an abortion before 14 weeks. Incomplete abortion was a critical outcome for this evidence review and can very distressing for women. Therefore, the committee agreed it was appropriate to offer cervical priming to all women. It is beyond the remit of NICE guidelines to comment on contracts with CCGs, however, the recommendations should highlight to commissioners the importance of appropriate funding to support these recommendations. The cervical priming regimens have been selected to minimise the time interval between priming and abortion to minimise duration of symptoms for the women, in recognition of the fact that many women will need to travel, and to minimise burden on services. There is no requirement for the GP to prescribe medication for cervical priming. This would be provided by abortion services either the day before or the morning of the abortion. The recommendations include alternatives to misoprostol that could be used if misoprostol was not available.

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				would need to be reflected in contracting arrangements with CCGs. The guidance needs to consider fully the key differences between environment and facilities between NHS and IHP settings, the difference in population of those accessing services within IHP settings, travel difficulties that clients face and difficulties in getting GPs to prescribe medication in advance of an abortion. There is currently a national shortage of misoprostol, and recommendations for its increased use should be made with caution.	
Marie Stopes UK	Guideline	19	6 - 9	We are concerned that the combined use of prior day osmotic dilators and either misoprostol or mifepristone may increase significantly the risk of premature labour. The guidance needs fully to consider the Independent Healthcare Provider (IHP) environment, context and clientele, and the potential for damage to carefully nurtured relationships between the IHP and local NHS services.	Thank you for your comment. Recommendation 1.12.8 states that misoprostol should not be given in combination with osmotic dilators due to the risk of preoperative expulsion. However, there was no evidence for an increased risk of this with a combination of osmotic dilators and mifepristone, which may have a benefit at increased gestational ages. This guideline stresses the need to establish better links between services and aims to improve this.
Marie Stopes UK	Guideline	19	10 - 15	There is currently a national shortage of misoprostol, and recommendations for its increased use need to be made with caution.	Thank you for your comment. The recommendations include alternatives to misoprostol that could be used if misoprostol was not available.
Marie Stopes UK	Guideline	21	14 - 15	We agree that providers should ensure that teams have the necessary skills and knowledge to provide all contraception options. Marie Stopes UK has a very active training and development	Thank you for your comments.

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				package for our team members and we are currently piloting an FSRH alternative approach to credentialing a range of healthcare practitioners in implant insertion.	
Marie Stopes UK	Guideline	21	8 - 13	Funding for the full range of provision of contraception is not always included within CCG contracts for abortion care services, where prices are set well below national tariff. Marie Stopes UK supports the NICE guidance recommendation, and would go further to propose that the inclusion of contraception should be standard within the contracting bundle.	Thank you for your comment, it is beyond the remit of NICE guidelines to make recommendations about CCG contracts. The recommendations relating to contraception in this guideline should highlight to commissioners the importance of appropriate funding to support these recommendations.
NUPAS	Guideline	5		**1.1.8, 1.19** What about when the client changes her mind on the same day, from being ambivalent to sure of decision ? Surely that is too quick and needs time to reflect rather than a hasty decision? Staff may not want to be identified on video calls- as they have potential to be recorded and posted on social media	Thank you for your comment. There is no legal requirement for an enforced waiting period. This information has been added to the rationale. Further, there is evidence (Cameron 2013) that the majority of women (93%) are sure of their decision to proceed at the point of requesting an abortion. However, recommendation 1.1.8 has been amended to say women should be provided with, or referred to support to make a decision if they request this. The committee discussed the issue of staff being videoed and agreed that this can be a concern. However, this would also be possible with face to face assessments so is not unique to video calls.
NUPAS	Guideline	8		The Guideline suggests the use of Dilapan between 14 weeks and the legal limit. Currently, most units only use Dilapan over 18 weeks. This would have an impact in the independent sector.	Thank you for your comment. On reflection, and in response to comments from stakeholders the committee agreed that: 1) between 14+0 weeks and 16+0 weeks, clinicians should consider using

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					osmotic dilators, mifepristone or misoprostol; 2) between 16+1 and 19+0 weeks clinicians should consider using osmotic dilators of misoprostol and 3) to offer osmotic dilators from 19+1 weeks, as there was no evidence to recommend an alternative after this time point.
NUPAS	Guideline	8		Possible typo – EMA criteria reads before 10+1, and after 10+0	Thank you for your comment. This was not a typo as, with the language used, the dates needed to differ by one day in order to include what happens at 10+0. However, we agree that this language may be confusing and it has been updated throughout the guideline and in the decision aid that will replace this table and be published alongside the guideline.
NUPAS	Guideline	10		Sepsis, perforation and severe bleeding are lumped together. These should be broken down. The perforation rate given for surgical termination between 13 weeks and the legal limit is recorded as < 1 in 100; does this mean 9 per 1,000 which is much higher than the RCOG figures?	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists. It was not possible to separate rate of sepsis, perforation and bleeding before 13 weeks as these values come from the National Abortion Statistics who did not report these outcomes separately (https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2017). The perforation rate for surgical between 13 and 24 weeks was based on evidence report K and no events of uterine perforation occurred. These figures have been amended in the PDA to say that it is a small number but it is not possible to say how many.

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NUPAS	Guideline	12	10	• whether there may be any movement. - what does this mean ?	Thank you for your comment. This is referring to whether there may be any movement of the fetus. This bullet has been combined with the one above for clarity.
NUPAS	Guideline	13		The Guidelines suggest not offering Rhesus testing before 10 weeks. They then go on to say that the Provider should ensure that anti-D prophylaxis is available at the time of TOP. To me, this doesn't make sense.	Thank you for your comment. The only group for which anti-D is not recommended in this guideline is those having a medical termination of pregnancy before 10+0 weeks. Therefore, anti-D is still required for women having a termination after this time point and may be required for women having a surgical termination of pregnancy before 10+0 weeks. The committee agreed it was important that this was available at the time of the termination so it does not cause delays. The bullet points of recommendation 1.3.4 have now been reordered for clarity.
NUPAS	Guideline	14	21	Has logistic and cost implications Surgical Termination, when cervical priming has been used, frequently results in faecal contamination of the operative field but the Guidelines do not recommend the use of Metronidazole. I don't find the reasoning behind this robust.	Thank you for your comment. The committee did not agree that cervical priming often results in faecal contamination of the operative field. Further, the medications used for cervical priming are also used for induction of labour where metronidazole is not routinely used. However, if there were concerns about faecal contamination, then the committee agree that it may be appropriate to use an antibiotic with anti-anaerobe properties.
NUPAS	Guideline	15	10	This would be unsafe practice	Thank you for your comment. The evidence review (see evidence report F) did not show any increased risks associated with performing an abortion before definitive ultrasound evidence. However, the wording of the recommendation reflects the fact that the evidence was not of a

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					sufficient quality to make a strong recommendation. This recommendation is consistent with guidance from the Royal College of Obstetricians and Gynaecologists (which states routine ultrasound scanning is unnecessary).
NUPAS	Guideline	18		The Guidelines state cervical priming reduces the risk of incomplete TOP in parous women. I think the use of ultrasound in theatre does this and am not sure of the mechanism by which cervical priming will achieve this. The Guidelines go on to say Dilapan should be considered in gestations over 14 weeks and to consider giving it the day before surgery. This would have a significant effect in our units **STI screening not highlighted- it is very important to offer STI screening at TOP ** Both self taken vaginal swabs for cHlamydia/gonorrhoea and finger prick blood tests for HIV	Thank you for your comment. There was good evidence that cervical priming reduced the risk of incomplete abortion and the force needed to dilate the cervix for women having an abortion before 14 weeks. Therefore, the committee agreed it was appropriate to offer cervical priming to all women. On reflection, and in response to comments from stakeholders the committee agreed that: 1) between 14+0 weeks and 16+0 weeks, clinicians should consider using osmotic dilators, mifepristone or misoprostol; 2) between 16+1 and 19+0 weeks clinicians should consider using osmotic dilators of misoprostol and 3) to offer osmotic dilators from 19+1 weeks, as there was no evidence to recommend an alternative after this time point. The committee recommended that overnight dilators are considered, not that they have to be used. The committee discussed the impact of overnight dilators on both women and services and that this may not always be possible. The rationale and the committee discussion in evidence report M have been updated to reflect these changes. The committee were not able to make a recommendation about STI testing as there was no question about this in this guideline. However, a cross-reference to NICE PH3 has been added, which covers guidance on

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					interventions to prevent sexually transmitted infections. PH3 is currently being updated.
NUPAS	Guideline	30		How does Rhesus testing delay treatment, as it only takes a few minutes and is done on site in most units?	Thank you for your comment. As outlined in the guideline (in the Rationale and impact Section; see also Evidence Report C), whether or not a delay is introduced as a result of Rhesus testing depends on how the service is set up. In the independent sector, point-of-care testing is used and anti-D is provided immediately. In contrast, NHS transfusion laboratories usually follow the same processes for managing anti-D as they do for managing whole transfusion systems. This is unnecessary and introduces delays, and means that women must choose between not having testing and prophylaxis and returning to the service after the abortion. To help reduce delays, the committee made a recommendation in line with current practice in the independent sector.
Right to Life UK	Guideline	General	General	There is a serious issue with the guidance regarding its intended scope. We understand that the scope of the guidance is intended to relate to providing the service once a decision has been reached. There are three major issues with this stipulation. Firstly, in reality there is no such definite point in a large proportion of patients' experiences. Ambivalence is extremely common among patients seeking a termination, including up until and after the point of termination (as exhibited in the cases cited by evidence review O, among other studies, e.g. Ingham et al., 2008, 'Reasons	Thank you for your comment. The guidance makes recommendations relating to the request for an abortion but the guideline scope does not cover how the woman makes that decision as this is covered by legislation and professional guidance. The 'this guideline covers' section has been amended to clarify the scope of this guideline and the introductory text has been amended to refer to the Abortion Act and the Department of Health Required Standard Operating Procedures, which provide additional guidance relevant to helping women make a decision. The evidence identified in our review indicates that self-referral improves access &

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				for Second Trimester Abortions in England and Wales', *Reproductive Health Matters*). So to limit the scope of the guidelines to those who have 'made a decision' with their doctors is to limit the scope of the guidelines dramatically and to exclude a significant proportion of women who in fact have terminations. Secondly, the guidelines appear to implicitly assume they are addressing situations before the decision has been made in some cases. For example, they recommend against having mandatory waiting times, the point of which are to allow women further time to make their decision. Likewise, a crucial element in the decision-making process is the woman's knowledge of the potential consequences of abortion, highlighted in 1.2.1. A woman should not have made a decision to terminate before being informed of the potential risks, and so it is unclear why 1.2.1 would be relevant after the decision has been made. Of course, it might be argued that she should be given reassurance and kept informed even after the decision has been made: but the same line of argument could be used precisely to argue that certain other things excluded from the scope of the guidelines should be re-iterated throughout the pregnancy process. Third, the lack of consideration of factors affecting the decision is simply a large omission that is crucially important to women's wellbeing. There	should result in abortions taking place at early gestations, and therefore with less complications. Our evidence review found that women want improved access and better information provision. There is also evidence (Cameron 2013) that most women (93%) are certain of their decision to not continue a pregnancy at the point at which they request an abortion. Therefore, once a women has requested an abortion she should not be faced with unnecessary delays due to the organisation of services. Recommendation 1.1.8 has been amended to say women should be provided with, or referred to support to make a decision if they request this, in response to yours and others' comments. All healthcare professionals providing abortion services must work within the constraints of the law and must obtain informed consent for any medical/surgical procedure. A note has been added to the beginning of the document to remind healthcare professionals to provide information and obtain informed consent in line with General Medical Council guidance (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent).

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				has been widespread concern among doctors and the public regarding factors that come before a woman's decision, including the pre-signing of abortion forms, the proper assessment of women prior to determining the legal status of her intended abortion, the potential risks associated with abortion and the lack of proper information given to women regarding these, and so on. Guidance in these matters would therefore be extremely important.	
Right to Life UK	Guideline	General	General	We propose that the cost-effectiveness of abortion as a medical procedure itself be evaluated. Given that cost-effectiveness is a key responsibility and interest of NICE, it is odd that the cost-effectiveness of abortion is assumed and cost-effectiveness of details of the service provision is the only element of cost-effectiveness. For most medical procedures, cost-effectiveness is analysed and those which are not cost-effective thereby generally have a prima facie mark against them when determining whether they should be publicly funded. Given that public funding of elective abortion is deeply controversial, a cost analysis is appropriate to help determine NHS spending policy. An additional reason for this is that it is an obvious area for saving: there appears to be no obvious health benefit to abortion (the standard medical indication given in 98% of cases is 'mental health - not otherwise specified' - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/679028/Abortions_stats_England_Wales_2016.pdf	Thank you for your comment. It was outside of the guideline scope to question whether or not to provide a termination of pregnancy so the committee were unable to make recommendations in this area.

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				- and yet it is widely agreed that there is no clear mental health benefit to abortion, as agreed by all major recent surveys on the topic). A considerable amount of NHS expenditure could thereby potentially be eliminated. While it might be argued that some procedures are assumed to be 'reasonable costs' regardless of their demonstrable cost-effectiveness and regardless of their demonstrable health benefit, it is not clear who should be the arbiter of such proposals. Who decides that abortion should be immune from cost analysis, and on what criteria? Even if public policy turns out to be that it should be publicly funded regardless of demonstrable health benefits, it is surely of public interest to know in the first place whether it does indeed have health benefits, and whether these are cost-effective. We propose therefore that NICE provide a reasoned judgment, consistent with their conducting cost analysis for other procedures, for why termination of pregnancy should be exempt from such an analysis. For such an analysis is surely of interest in determining public policy on this question.	
Right to Life UK	Guideline	4	11	Given the strain on GP (and other) services, it is not clear how this would work in practice. Booking the patient in to see another GP could take a week or longer, and there is no obvious way to work around this – to some extent delay is inevitable. The guidance therefore seems practically inaccessible to clinicians actually wanting to use it.	Thank you for your comment. This recommendation is consistent with professional guidance (e.g., the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice) as healthcare professionals have a right to their personal beliefs and to opt out

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				Moreover, there is no discussion of what a clinician should do if they feel an abortion not indicated clinically or indeed does not meet the criteria of the 1967 Abortion Act.	of performing a procedure, but cannot opt out of providing access. Additional information has been added to the rationale to clarify this. Recommendations 1.1.1 and 1.1.2 make it possible for a GP, should they have a conscientious objection, to give the patient information on how to self-refer and therefore not lead to a delay. A statement has been added to the guideline to remind healthcare professionals that all care must be given within the constraints of the Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990).
Right to Life UK	Guideline	5	4	This is not sufficiently sensitive to a) the frequency of pressured abortions, and b) the fact that women overwhelmingly support (77%, while only 10% oppose) mandatory waiting periods (https://www.comresglobal.com/wp-content/uploads/2017/05/Where-Do-They-Stand-Abortion-Survey-Data-Tables.pdf). Even if the guidelines consider only evidence from women who have abortions, it appears likely (given that a third of women will have abortions in their lifetime) that most women having abortions support a mandatory waiting period, and a minority oppose it). There are other recent polls suggesting that people generally want medical supervision by doctors throughout. For example, a 2014 survey (https://www.comresglobal.com/wp-content/themes/comres/poll/Christian_Institute_Abortion_Survey_3rd_March_2014.pdf) showed 92% of women thought they should always be seen in person by a doctor when requesting an abortion.	Thank you for your comment. There is evidence (Cameron 2013) that most women (93%) are certain of their decision to not continue a pregnancy at the point at which they request an abortion. Therefore, once a women has requested an abortion she should not be faced with unnecessary delays due to the organisation of services. However, recommendation 1.1.7 was included to ensure that women can wait longer to have an abortion if they would prefer this for whatever reason, including if she is still considering her options. Recommendation 1.1.8 has also been amended to say women should be provided with, or referred to support to make a decision if they request this. The rationale has been expanded to clarify this.

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Right to Life UK	Guideline	5	7 - 14	Again, this neglects the overwhelming opinion of women that a) a woman requesting an abortion should always be seen in person by a qualified doctor and b) the health of women considering an abortion will be put at risk otherwise (https://www.comresglobal.com/wp-content/themes/comres/poll/Christian_Institute_Abortion_Survey_3rd_March_2014.pdf). There is also evidence suggesting most women think doctors should verify *in person* that a woman is not under pressure to have an abortion (https://www.comresglobal.com/wp-content/uploads/2017/05/Where-Do-They-Stand-Abortion-Survey-Data-Tables.pdf).	Thank you for your comment. There is no statutory requirement for women to have been seen in person by a doctor. It is part of basic clinical practice for healthcare professionals to be alert for signs of physical or emotional abuse or coercion and it is not necessary to see a women in person in order to do this. A reference to the Department of Health Required Standard Operating Procedures, and other relevant legislation and guidance, has been included in the introductory text and a note has been added to the beginning of the document to remind healthcare professionals of their duty to ensure they are adhering to all applicable requirements.
Right to Life UK	Guideline	5	15 - 24	It is of paramount importance that there is no pressure for conscientiously objecting doctors to engage with such training. And it is doubtful that it should be considered the 'default' given that the majority of doctors 'would not perform' the overwhelming majority of abortions (Gleeson et al., 2008, 'Medical students' attitudes towards abortion: a UK study', *Journal of Medical Ethics*: only 37% would perform if 'child unwanted'; 38% would perform if the foetus was at risk of serious disability; 46% if foetus guaranteed to have serious disability). This is especially important since there is evidence that conscientiously objecting doctors are liable to performing them due to pressure within work (Strickland, 2011, 'Conscientious objection in medical students: a questionnaire survey', *Journal of Medical Ethics*: shows a significant discrepancy between those	Thank you for your comment. Conscientious objections is covered by legislation and professional guidance (e.g., the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent). Whilst the guideline makes recommendations about the principles under which training should be delivered, the specific content of training is beyond the scope of NICE guidelines. The views of staff were considered in relation to factors that help or hinder the accessibility and sustainability of abortion services; attitudes to abortion were not considered as part of this guideline.

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				who have an objection to the procedure and those who would refuse to perform it). In particular, there is evidence that Muslim doctors are particularly pressured to go against their religious beliefs (significant anecdotal evidence provided by the British Islamic Medical Association; see also Strickland 2011, which shows a big discrepancy between 'conscientiously objects' and 'would not perform' for Muslims in particular). Therefore we recommend an opt-in system and some sort of regulation or mandatory feedback for students to check whether they felt any pressure to go against their beliefs. Likewise, medical students and trainees should be warned about what the procedure may involve and what it will look like. Should also take into account the possible negative psychological effects of witnessing and performing abortion on students (http://www.life.org.nz/abortion/abortionmedicalkeyissues/abortionclinicstaff1/). We recommend also comprehensive teaching on the law, reality, and ethics of abortion developed jointly by pro-choice and pro-life clinicians to fairly represent the range of views within the medical profession, after significant anecdotal evidence of extremely partisan teaching on this subject at various universities. We also recommend the same for nursing students, and recommend that this includes information on clinical assessment for whether they meet the legal criteria, in line with the best evidence on physical and mental health. We recommend also accurate resources made	

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				available for religious doctors so that they can practise in accordance with their faith. Given that the only studies supporting this recommendation are 'very low quality' according to the draft guidelines, we think that these considerations deserve serious deliberation. In the evidence reviews, it is claimed that "the view of both women and staff in termination of pregnancy services should be considered to capture a broad range of perspectives". However, they do not appear to consider the views of staff much, especially not vulnerable minority groups of staff, for example, Muslims who may be pressured to perform abortions or take part in training against their conscience. As described, the views of much larger samples of women in polling data were not used.	
Right to Life UK	Guideline	7	2 - 4	The RCPsych stresses the requirement for patients to be given adequate and appropriate information regarding mental health consequences of abortion in order for informed consent to be achieved (https://www.wthrockmorton.com/2008/08/20/royal-college-of-psychiatrists-statement-on-abortion-and-mental-health/ - original document unavailable on RCPsych website). The *Montgomery v Lanarkshire* ruling has clarified the standard in law requiring that patients are told of any outcomes they would reasonably want to know.	Thank you for your comment. The committee agree that it is necessary to fully inform women of risk associated with having an abortion but have not made exhaustive recommendations about this as it is part of good clinical practice. The introductory text has been amended to remind healthcare professionals to provide information and obtain informed consent in line with General Medical Council (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent) guidance and the 2015 Montgomery ruling. The evidence for long-term health risks was not formally reviewed as part of this guideline. However, the committee agreed that a

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				The guidelines deny that there is an increased risk of long-term health problems. This is problematic for two primary reasons. Firstly, and more simply, abortion appears to cause an increased risk of preterm birth. The link is noted by the RCOG (https://www.wthrockmorton.com/2008/08/20/royal-college-of-psychiatrists-statement-on-abortion-and-mental-health/) even though they say there is insufficient evidence to imply causality. However, they do not rule out causality, so it is false to state categorically that there is no causative link. It is an open question whether abortion causes an increased risk in preterm birth and women should be made aware of this. Secondly, there is a longstanding debate and as yet unresolved debate on the link between abortion and mental health, and it is not accurate to tell patients in a categorical manner that abortion does not increase one's risk of mental health problems. The most recent major meta-analysis, by the pro-choice psychologist David Fergusson, in the *Australia and New Zealand Journal of Psychiatry* (Fergusson et al., 2013, 'Does abortion reduce the mental health risks of unwanted or unintended pregnancy? A re-appraisal of the evidence', *Aus & NZ J Psych*) concludes that abortion is associated with an increased risk in anxiety, substance abuse, alcohol abuse, and suicidal behaviour. No major	recommendation should be included that reassures women there is no increased risk of infertility, breast cancer and mental health problems as these are covered in the RCOG guidelines and are frequently mentioned despite the best available evidence showing that is not the case. The language in recommendation 1.2.1 has been amended to just mention infertility, breast cancer and mental health problems, not all long-term risks. The committee acknowledge that there may be some evidence (although this was not reviewed as part of this guideline) of an association between abortion and risk of subsequent pre-term birth but agreed that the evidence for this is less definitive than for the risks discussed above and so did not make recommendations. The committee were aware that the Academy of Medical Royal Colleges guidance showed that following an unwanted pregnancy, there was not an increased risk of having mental health problems in women who had an abortion compared with those who have birth. The Ferguson review cited did not control for pre-existing mental health problems, which are more likely to occur again irrespective of whether a woman has an abortion. Further, the Ferguson review acknowledges that comparing women with an unwanted pregnancy that had an abortion with women with an unwanted pregnancy that decided to continue to term may not be the appropriate comparison. They said a more appropriate

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				review has contradicted his results since, and the evidence review did not even consider his paper for the draft guidelines, despite his being one of the leading researchers on the topic. Indeed, the review cited by the evidence review (AOMRC 2011) considers one of Fergusson's primary studies showing the same result as one of the two best studies on the subject. None of the other sources cited by the evidence review give an analysis of the evidence on mental health. The AOMRC survey does, in fact, say that 'there was some limited evidence to suggest increased rates of self-harm following an abortion, but only in the unplanned group', thereafter concluding that it was not clear that this was a causal association. But, as with preterm birth, the jury is still out on whether this association is causal, and prominent researchers like Fergusson have argued that they are (detailed argument is given in Fergusson et al., 2008, 'Abortion and mental health disorders: evidence from a 30-year longitudinal study', *British Journal of Psychiatry*). Fergusson has, of course, provided evidence for a causal relationship in his more recent meta-analysis by showing that the associations between abortion and poor mental health (which are relatively uncontroversial - the debate is whether they are attributable to confounding factors or not) persist even after adjustment for confounding factors (Fergusson et al., 2013).	comparison may be to compare against women with an unwanted pregnancy who were refused an abortion. They were only aware of one study that did this (Gilchrist 1995), but this study showed a higher rate of psychotic illness in women refused an abortion. Therefore, the committee concluded that there was no robust evidence of a link between abortion and mental health problems. The committee agreed it was not appropriate to provide detailed information about how a woman might feel after an abortion as this could make them feel worse. This is explained in the committee discussion of evidence report O.

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				As suggested, the debate is not primarily whether there is a link between abortion and poorer mental health - the debate is whether the link is causal. But in the absence of a clear consensus otherwise, women deserve to know (and arguably doctors have a legal duty under *Montgomery* to comply) that there is an association, pending a consensus among researchers regarding whether the link is causal. It is worth noting in connection that a US Court of Appeals noted that it was standard practice to 'recognize a strongly correlated adverse outcome as a 'risk', even while further studies are being conducted to investigate which factors play causal roles." (8th Circuit, *Planned Parenthood Minn, ND, SD v Rounds, 2012*). In any case, as described, the most recent major review, more up-to-date than anything cited by the draft guidelines evidence reviews, concludes that there is an increased risk of certain disorders from abortion compared to continuing an unwanted pregnancy. And there are other major recent reviews concluding the same (e.g. Coleman, 2011, 'Abortion and mental health: quantitative synthesis and analysis of research published 1995-2009', *British Journal of Psychiatry*). A final point would be that typical guidance on this point says that women should be warned of the varied emotions of those who have abortions. My	

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				own experience as a clinician suggests that this is not adequate information, as it does not make clear the very serious emotional and mental health consequences of abortion. I have had patients who have been suicidal and who have blamed this on their abortions, and such patients' experiences are worth taking seriously. *Even if* abortion does not increase one's risk of mental health problems (as I have argued is an open question and, in my estimation, unlikely), it uncontroversially does cause or contribute to serious mental health problems, even if at the same rate as pregnancy (Reardon, 2018, 'The abortion and mental health controversy: A comprehensive literature review of common ground agreements, disagreements, actionable recommendations, and research opportunities, *SAGE Open Medicine*). It is important that women know this as they might regard mental health difficulties resulting from abortion as more unacceptable than mental health difficulties arising from continued pregnancy. Hence, women should be informed that abortion can contribute to suicidal ideation (inter alia), even if the possibility remains that pregnancy causes suicidal ideation (inter alia) at the same rate.	
Right to Life UK	Guideline	11	6 - 8	The guidelines recommend that the experiences of women undergoing abortions should be included. As the corresponding evidence review highlights, however, many women find that the video presentations given in such cases are unrepresentative of the whole spectrum of responses, and often more positive than their own	Thank you for your comment. The recommendation states that information should be based on women's experiences, without specifying whether they should be positive or negative.

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				experience. It would, therefore, be appropriate to properly inform women to include the whole range of responses to abortion, including those who had a strongly negative reaction to their abortion. Videos used of women's experiences should therefore reflect this.	
Right to Life UK	Guideline	12	5 - 6	Women should be educated in particular on failure rates (both from perfect use and typical use) of various contraceptive devices. In my clinical experience women are virtually never told about these or given accessible information regarding the likelihood of an unwanted pregnancy per year (and per reproductive lifetime) given the use of a particular contraceptive device. This information should also be given to doctors to help inform patients. We also recommend that doctors are informed and can inform patients on the possible abortifacient mechanisms of certain contraceptives (in particular, copper IUDs, but for all those methods where there is evidence for or uncertain evidence regarding an abortifacient mechanism). Though this is not legally required, it is of essential importance for respecting the personal beliefs of patients (particularly Christians and Muslims) who object to abortion from fertilisation rather than the legal definition of implantation. Again, I have never met a single patient who has been given this information by their doctor, and most doctors I have spoken to	Thank you for your comment. It was not possible to make recommendations about the effectiveness or abortifacient mechanisms of different methods of contraception as this evidence was not reviewed as part of this guideline. The committee are aware of guidance from the Faculty of Sexual and Reproductive Healthcare about contraception use after pregnancy. This information has been added to the discussion in evidence report B.

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				have not even had the information available in the first place. The same considerations apply for section 1.15 on contraception.	
Right to Life UK	Guideline	12	7 - 10	The evidence reviews suggest that women were not prepared for the experience of delivering the dead foetus and appreciated *detailed* information on this. The need for detailed information is not adequately reflected in the draft guidance: it would be helpful for clinicians to know precisely what to include - specifically, that the foetus may well look like a human being, have identifiable body parts, may well move of its own accord, etc. It is also not clear what detailed information should be given regarding the nature of the procedure: not just what the woman experiences but also what the procedure involves in cases of medical and surgical abortions, particularly if there is a risk (as in medical abortions but also sometimes in surgical abortions) that the woman will see the body parts of the foetus.	Thank you for your comment. The guideline refers to various gestations in the recommendations, and it would not be clinically accurate to refer to the products of conception as a fetus until later gestations. Therefore, the decision was taken by the committee to use the term 'pregnancy' throughout the recommendations for accuracy and consistency. Recommendation 1.2.7 states that healthcare professionals should inform women about what they should expect to see and what the pregnancy may look like when she passes it. This will differ depending on the gestation and therefore the committee agreed that this recommendation would prompt healthcare professionals to use their clinical judgement to give women the relevant information for their gestation. The recommendation does specify that women should be told that there could be movement and that they may see the pregnancy as they pass it. The language in evidence report B has been amended to be consistent with the recommendations.
Right to Life UK	Guideline	12	11 - 12	Again, detail on how this ought to be achieved would be helpful: what specific information should the woman be given?	Thank you for your comment. A cross-reference has been added to the recommendations on follow-up (1.14.1 and 1.14.2).
Right to Life UK	Guideline	20 - 21	9 - 6 (next	Given the detailed evidence review showing that women generally have very negative experiences	Thank you for your comment. The guideline is for people who have requested an abortion and

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			page)	of termination after foetal anomaly, it is worth giving women detailed information from evidence base regarding the experiences both of children born with certain conditions and of women who have given birth in such conditions (including for fatal foetal anomaly / life limiting conditions). For example, a recent study from Wool et al. (Wool et al., 2018, '"I would do it all over again": Cherishing time and the absence of regret in continuing a pregnancy after a life-limiting diagnosis', *Journal of Clinical Ethics*) found that the overwhelming majority (97.5%) of parents had no regret about their decision to continue the pregnancy in the case of FFA. Likewise, there is one study directly comparing the mental health outcomes of those having an abortion and those continuing a pregnancy in such a situation, showing that women have better mental health outcomes if they continue the pregnancy (Cope et al., 2015, 'Pregnancy continuation and organizational religious activity following prenatal diagnosis of a lethal fetal defect are associated with improved psychological outcome', *Prenatal Diagnosis*). This should be conveyed to women in such a situation. Likewise, it is worth giving women access to studies showing that children born with certain disabilities tend to be extremely satisfied with their lives. For example, Skotko et al. published a paper (Skotko et al., 2011, 'Self-perceptions from People with Down Syndrome', *American Journal of Medical Genetics Part A*) showing that people	covers safe and effective abortion care. Therefore, information about a fetal anomaly is outside the scope of this guideline. This information should be provided by the maternity service or fetal medicine specialist that diagnosed the anomaly. The committee agreed that it would not be in the best interest of women to be prescriptive about how they will feel after an abortion as this may cause women to feel worse. This is explained in the committee discussion in evidence report O.

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				born with Down Syndrome overwhelmingly value their lives and appreciate the opportunity to live. By contrast, the negative experiences highlighted in the evidence review from women having abortions in such situations should be offered in comparison (e.g. the theme of experiencing the abortion as 'torture' highlighted in Jones et al., 2017, 'Women's experiences of labour and birth when having a termination of pregnancy for fetal abnormality in the second trimester of pregnancy: A qualitative meta-synthesis', *Midwifery*). Even if this response is rare (which is not clear), it should be highlighted specifically to women as a rare but serious consequence. The language of a 'range of emotions' clearly does not adequately convey the severity of such responses to abortion.	
Right to Life UK	Guideline	20 - 21	9 - 6 (next page)	Separate comments on psychological support: It is worth recommending screening for women particularly at risk of mental health problems following an abortion, as recommended in the *RCPsych* position statement (https://www.wthrockmorton.com/2008/08/20/royal-college-of-psychiatrists-statement-on-abortion-and-mental-health/). Indeed, it would be helpful to direct clinicians to resources and information regarding such screening so that they can carry this out properly. Given that the evidence review makes clear that women struggle in getting access to emotional support after abortion, more robust	Thank you for your comment. We did not review the evidence for components of assessment or mental health screening for abortion as this was not in the scope of the guideline. Therefore, the committee could not make recommendations in this area. The committee did not specify where counselling should be provided as some women may prefer to have this within the abortion service to maintain privacy and confidentiality, but others may want independent counselling which has been suggested by other stakeholders. The committee also agreed that, beyond a certain threshold, it may not be in the best interest of the woman to have counselling within the service as they are unlikely to have as much expertise as

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				recommendations should be made for the provision of such care, and a robust recommendation regarding who should be responsible for providing such care (should private abortion providers be obliged to run a service, for example?). There is very little in the guidance on how to improve access to such care, despite a major theme being the lack of access, and indeed the facts that a) women felt the access to support diminished over time despite a continuing need, and b) women often regretted initially declining emotional support. All the evidence in the evidence review is in favour of an opt-out system for emotional support after an abortion. Indeed, this is even implied by the guidance. However, it is claimed that such a system would be unreasonable because 'some women do not feel they need support and may actually feel relieved after a termination of pregnancy and want to move on.' This appears to make little sense, since such women can decline the offer of support very easily, and since the overwhelming weight of evidence regarding emotional support suggests that there is not enough, rather than that it is inappropriately offered (it is not clear whether there is any evidence at all of the latter, in fact). We therefore propose that such follow-up be offered as standard with an opt-out possibility for women who do not wish to have post-abortion support.	specialist services. Therefore, the recommendations have been left as 'provide or refer' to give services and women the options of both providing this in house and referring to independent services. The wording of the discussion in evidence report O has been amended to provide additional information about why the committee agreed it was not appropriate to offer everyone counselling, as this may set the expectation that women will feel bad and need counselling, which could make them feel worse. It was beyond the scope of this guideline to recommend exact pathways for referral as evidence on the most effective referral methods were not reviewed.

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				Such support should be offered routinely by abortion providers, in line with committee recommendations that it 'is important that emotional support, and access to counselling if required, is available from termination of pregnancy providers as this would not require additional disclosure by the women in order to access support.' Given the clear lack of access to support described by women, there is compelling reason to include such a mandate in the final guidance. The guidance should make clear that there is a recommendation of a formal requirement for abortion providers in this respect, and that this should not be limited to the period after pregnancy but should be an ongoing offer for those women who initially decline, and for those women who need ongoing support for an extended period of time. The evidence review says that '"The committee noted that difficulties experienced by some women may require more intensive psychological therapy, which is often not available from termination of pregnancy services and that there can be difficulties providing referrals for these women; however, recommending pathways for referral was beyond the scope of this question."' However, it is unclear on what grounds this is outside the scope of the guidance.	
Right to Life UK	Evidence review A	39	45	It is described that the committee agreed that women should be given information on how to cancel their appointment or procedure, although	Thank you for your comment. Women have the right to change their mind and clinicians should follow professional guidance (e.g., the General

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				this is not in the final guidelines. It is not clear that this would be standard procedure for a given operation or procedure (certainly I have rarely heard it in all my time as a clinician) and so warrants particular mention here given the frequent ambivalence and reasonably common regret expressed by women undergoing abortions, especially given the emphasis in the guidelines of speeding the process along and carrying out the abortion as soon as possible.	Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent).
Royal College of Anaesthetists	Guideline	General	General	In addition to the current section 1.13 Anaesthesia and sedation for surgical termination, we would like to see: 1) A comment on food and fluid restriction before the various forms of anaesthesia 2) A comment on staffing and facilities for the various forms of anaesthesia 3) A comment on the necessity to be accompanied home after deep sedation or GA	Thank you for your comment. Food and fluid restriction and staffing and facilities for anaesthesia are covered by good clinical practice and outside the scope of this guideline. The need for women to be accompanied home after sedation or general anaesthesia has been included in a patient decision aid (PDA) that has replaced Table 1 and will be published at the same time as the guideline to help women make an informed decision about methods of termination/anaesthesia.
Royal College of Anaesthetists	Guideline	19	21	In response to the suggestion that patients will leave earlier if procedure under LA. The anaesthetic is not the rate limiting step here.	Thank you for your comment. The committee agree that there are other factors that contribute to how long women will have to stay in clinic/hospital after an abortion but anaesthesia is one of these factors. If a woman has not had any complications she would normally be able to leave sooner if she has not had sedation or general anaesthesia.
Royal College of Anaesthetists	Guideline	20	1	Patients are not entirely unconscious when under deep sedation, per the definition deep sedation in the Academy of Medical Royal Colleges' guideline "Safe sedation".	Thank you for your comment. This has been amended to 'they will not usually be aware during the procedure'.

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Royal College of Anaesthetists	Guideline	20	5	It is unclear as to whether they mean avoid inhalational induction, or if they are specifically encouraging TIVA. The evidence in the link is decidedly weak but they shy away from specifying they really do mean TIVA.	Thank you for your comment. It was not possible to make a stronger recommendation based on the evidence reviewed.
Royal College of Anaesthetists	Guideline	23	21	It is unclear what is meant by "optimal". Achieving unconsciousness is rarely the issue, so perhaps specify what the intended, ideal endpoints are here. Blood loss? Post operative nausea and vomiting (PONV)? Analgesia? …"Which anaesthesia techniques help reduce blood loss, minimise pain, enhance recovery, minimise PONV?"	Thank you for your comment. Outcomes are not normally specified in the review question. The outcomes of interest (blood loss, uterine contractility, nausea, vomiting and patient acceptability) are included in the PICO table in appendix L of evidence report N.
Royal College of General Practitioners	Guideline	General	General	The RCGP have a position statement and the role the GP, which can be found here: https://www.rcgp.org.uk/policy/rcgp-policy-areas/abortion-position-statement.aspx	Thank you for your comments.
Royal College of General Practitioners	Guideline	4	6	The committee should consider making a recommendation to agree streamlined pathways between providers	Thank you for your comment. The third bullet from recommendation 1.1.16 about minimising the need for women to repeat key steps has been moved up to this recommendation to make it clear that this should apply whenever women need to be referred to another service.
Royal College of General Practitioners	Guideline	4	11	The committee should consider expanding this statement to explain that the healthcare professional is entitled to their own personal beliefs but this must not influence the care they provide. They may conscientiously object to	Thank you for your comment. The committee did not think this recommendation needed expanding as it is consistent with professional guidance (e.g., the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-

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				actively participating in a procedure however they must ensure a seamless pathway to a healthcare professional who is able to provide the information and referral requested.	doctors/personal-beliefs-and-medical-practice) and it is not the focus of this guideline to provide further guidance on this. However, the rationale section has been expanded to make it clear that healthcare professionals have a right to their personal beliefs and to opt out of performing a procedure, but cannot opt out of providing access.
Royal College of General Practitioners	Guideline	4	21	This is sound guidance, and the rationale & impact section includes robust reasons for making it. Clearly women requesting terminations should not have to face unnecessary delays. However it is predictable that this will become a quality standard. The problem arises with women who are, at the time of presenting, unsure of what they want who may then be encouraged to take a decision more quickly than they would want. The committee should rephrase this recommendation so that it accommodates such women.	Thank you for your comment. Recommendation 1.1.7 gives women the option of waiting longer if they would prefer this and the language in recommendation 1.1.6 makes it clear that this is an ideal time frame, not an absolute requirement. This comment will be passed to the quality standards team for consideration.
Royal College of General Practitioners	Guideline	5	4	We agree it is wrong to require women to have counselling. However, is there a risk that this recommendation will make it more difficult for women who would like counselling to get it? The committee should consider adding clarification around this recommendation to ensure that women who want counselling are able to access this.	Thank you for your comment. Recommendation 1.1.8 has been amended to say women should be provided with, or referred to support to make a decision if they request this.
Royal College of General Practitioners	Guideline	6	8	Providers should develop 'seamless' pathways.	Thank you for your comment. 'Seamless' pathways is covered by the third bullet point 'avoid the need for women to repeat key steps'. This bullet has been moved to recommendation 1.1.1

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					to clarify that this should apply to all women when a referral is needed.
Royal College of General Practitioners	Guideline	7		**Table 1** This is confusing as the language at times is for patients and at others for clinicians and others for commissioners. Please make this clearer and be consistent with the language	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists to ensure the PDA is written using consistent and clear language.
Royal College of General Practitioners	Guideline	7	11	Women should always be given a choice even when there are differences between the options in terms of effectiveness and safety. The committee should rephrase this sentence to reflect his. As it currently stands it implies that women should only be offered a choice when there is equipoise between two options	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA does not include the text you refer to. Recommendation 1.2.1 has been amended to include 'taking account of their needs and preferences'.
Royal College of General Practitioners	Guideline	11		**Table 1** This should be about access to all methods of contraception	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists. The PDA will list all forms of contraception mentioned in the NICE guideline, with the following wording: "*You can start contraception straight away after an abortion. You can choose whichever type of contraception is best for you, and your healthcare professional can help you decide. There are long-acting methods available, and with these you don't have to take a pill every day. Long-acting contraceptives include injections or implants, or an IUD (the coil) or IUS (hormonal coil) placed in the*

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					womb (called 'intrauterine' devices or systems). Other methods of contraception include oral contraceptives, contraceptive patches, vaginal rings or barrier contraception (for example, condoms).'
Royal College of General Practitioners	Guideline	12	25	The committee should consider adding a recommendation about access to ongoing support and recommendation to advise information sharing with GP if appropriate after termination for foetal anomaly so that records can be amended and ongoing support offered as appropriate	Thank you for your comment. A bullet has been added to recommendation 1.2.11 to facilitate ongoing support from the maternity service. Evidence showed that some women were disappointed when healthcare professionals encountered during follow-up care were not aware that the woman had an abortion for fetal anomaly. However, the committee agreed it was not appropriate to recommend that the abortion is disclosed to GPs due to concerns with privacy and confidentiality that arose during the review of access to abortion services. This is explained in the committee discussion in evidence report O.
Royal College of General Practitioners	Guideline	13	14	The committee should consider making a recommendation about STI testing to reduce ongoing transmission	Thank you for your comment. There was not a question about STI and HIV testing within the scope of this guideline so recommendations could not be made in this area. However, in response to stakeholder comments a cross-reference to NICE PH3 has now been included (under the section on preventing infection) which covers guidance on interventions to prevent sexually transmitted infections. PH3 is currently being updated.
Royal College of General Practitioners	Guideline	14	21	Please clarify that it is the responsibility of the termination provider to dispense this to the woman.	Thank you for your comment. The committee agreed that this should be dispensed by whoever has made the assessment that thromboprophylaxis is required. So for women who are already on thromboprophylaxis, they may

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					continue to receive this from another service, for example their GP. However, if a woman is not already on thromboprophylaxis it would be the responsibility of the termination service to provide this. This has been clarified in the committee discussion in evidence report E.
Royal College of General Practitioners	Guideline	15	3	Please clarify that it is the responsibility of the termination provider to dispense this to the woman.	Thank you for your comment. The committee agreed that this should be dispensed by whoever has made the assessment that thromboprophylaxis is required. So for women who are already on thromboprophylaxis, they may continue to receive this from another service, for example their GP. However, if a women is not already on thromboprophylaxis it would be the responsibility of the termination service to provide this. This has been clarified in the committee discussion in evidence report E.
Royal College of General Practitioners	Guideline	16	8	The committee should consider making a recommendation that for medical termination at home information must be provided to the woman with provider contact details if she has any concerns.	Thank you for your comment. Recommendation 1.14.3 covers providing women with information about what to do if they have any problems and how to get help.
Royal College of General Practitioners	Guideline	22	6	The committee should consider adding a recommendation about providers and commissioners agreeing that the provider will dispense 3 months CHC or POP if the woman chooses a short acting method of contraception.	Thank you for your comment. However, this is a commissioning decision, so is outside the scope of this guideline.
Royal College of Nursing	General	General	General	The Royal College of Nursing (RCN) welcomes the NICE draft guidelines on the termination of pregnancy.	Thank you for your comments.

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				The RCN invited members who work with women to review the draft guidelines on its behalf. The comments below reflect the views of our reviewers.	
Royal College of Nursing	General	General	General	We welcome this clear guidance and the introduction about the role of nurses and midwives within the role TOP.	Thank you for your comments.
Royal College of Nursing	Guideline	9		**Table 1** We are unsure what '*special type of pregnancy test'* the guidelines are referring to here for follow up after termination of pregnancy (TOP)? It is usual practice to carry out a standard pregnancy test.	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists. The PDA does not go into this detail about the pregnancy test since this is a patient facing document.
Royal College of Nursing	Guideline	9		**Table 1** We would be concerned about women having a TOP at 9/40 +6 at home. In practice we would recommend patients over 9/40 (for example those who have had a miscarriage, though slightly different) were inpatients for medical management.	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The recommendation for expulsion at home for women up to 10+0 weeks gestation is based on the evidence (as detailed in Evidence Report G) that showed no higher risk of serious complications (such as the need for emergency care/hospitalisation and haemorrhage requiring transfusion or > 500ml of blood loss) and adverse events like vomiting and diarrhoea between women with gestational age ≤ 9+0 and 9+1 to 10+0 weeks.
Royal College of Obstetricians and Gynaecologists	Guideline	General	General	A well written guideline with good reasoning for the recommendations	Thank you for your comments.

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Royal College of Obstetricians and Gynaecologists	Guideline	General	General	Consider inclusion of feticide for medical abortion (see 6.21, The Care of Women Requesting Induced Abortion (Evidence-based Clinical Guideline No. 7))	Thank you for your comment. The committee did not prioritise feticide during protocol development so the committee were unable to make recommendations in this area. The evidence reports for medical termination of pregnancy between 10 and 24 weeks gestation (Evidence Report J) and after 24 weeks gestation (Evidence Report L) acknowledge the RCOG 2010/2011 guidance that recommends feticide after 21+6 weeks' gestation. This information has also been added to the relevant rationale sections to explain why recommendations were not made. This will be highlighted to the NICE surveillance team to be aware of when conducting update searches in the future.
Royal College of Obstetricians and Gynaecologists	Guideline	General	General	All pregnancy dating should be consistent with the latest advice from the Chief Medical Officer (i.e. 24+0 should be articulated as 23+6)	Thank you for your comment. 'Before 24+0' has been amended to 'up to and including 23+6' throughout.
Royal College of Obstetricians and Gynaecologists	Guideline	3		"misoprostol only has a UK marketing authorisation for use of 400 micrograms orally up to 49 days, or 800 micrograms vaginally" All other uses recommended in this guideline are unlicensed. Assume that the above means 'gestation up to 49 days'. Also, the statement that "all other uses" of misoprostol are unlicensed needs clarification. Does this mean its use for higher gestations or its use for cervical priming etc.? The current edition of the BNF states that misoprostol can be used for TOP following mifepristone for gestations up to 24 weeks,	Thank you for your comment. The marketing authorisations have been updated to reflect the summary product characteristics. The sentence has been amended to "All other uses of misoprostol and mifepristone recommended in this guideline (including misoprostol for cervical priming and abortion at later gestations) are unlicensed." for clarity.

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				although it acknowledges that doses for TOP may differ from those in product literature.	
Royal College of Obstetricians and Gynaecologists	Guideline	5	4 - 5	This sentence doesn't read very well. Suggest 'Women should not be required to have compulsory counselling etc.	Thank you for your comment. The committee agreed that 'women should not be required' was not as strong as 'do not require women' so have not amended this recommendation.
Royal College of Obstetricians and Gynaecologists	Guideline	8		The text says that medical termination avoids the need for surgery and general anaesthetic. It doesn't avoid surgery, it reduces the chance of the woman requiring surgery	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA does not include the wording you refer to.
Royal College of Obstetricians and Gynaecologists	Guideline	8		There is no injury to the cervix with medical abortion	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA clarifies that there is no injury to the cervix with medical abortion.
Royal College of Obstetricians and Gynaecologists	Guideline	8		Some of the complications in the table are given as figures from 100 women, others from 1000 women. Generally I think people find figures /100 easier to understand and remember. There should be consistency on the information given.	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists. There will be 2 separate PDAs, one covering abortion before 14 weeks and one 14-<24 weeks. The lowest possible denominator is used for each PDA, with the same denominator used for all statistics within a PDA. For the <14 week PDA the denominator is x/1,000 because the risk of complication as reported in the national statistics is 1/1,000. This could be expressed out of 100 using either 0.1/100 or <1/100, but this could either be potentially confusing or less accurate compared with 1/1000. For the 14-24 week PDA the

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					denominator is x/100 (with the same denominator for all statistics).
Royal College of Obstetricians and Gynaecologists	Guideline	8		Surgery under 14+0. Description of sublingual misoprostol that goes under the gum and may cause bleeding and pain. It could be read that this causes bleeding and painful **gums**, rather than vaginal bleeding and abdominal pain	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists. The pain and bleeding section has been rewritten for clarity.
Royal College of Obstetricians and Gynaecologists	Guideline	9		Table column under follow-up: "After 10+0 weeks- No routine follow-up is necessary". The reasoning behind this recommendation should be made clear. Why this should be different to gestations before 10+0 weeks? Suggest that a pregnancy test after about 2 weeks is recommended to confirm that the pregnancy has ended or at least some form of follow-up e.g. telephone consultation to exclude ongoing pregnancy	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The committee agreed that follow-up was only necessary before 10+0 weeks when women have gone home to pass the pregnancy, otherwise the expulsion would have been witnessed by a healthcare professional.
Royal College of Obstetricians and Gynaecologists	Guideline	10		Data previously shows info with decision making either side of 14+0, In the last section this changes to 13+0. Was this intentional?	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists. The gestational age limits included in the table were intentional as they corresponded to gestational limits used in the different evidence reviews. However, these are being reviewed in the PDA to make the resource easier to use in practice.

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Royal College of Obstetricians and Gynaecologists	Guideline	12	5 - 6	Text says 'ask women' if they would like information on contraception. This needs to be much stronger. Consider the term "provide women". A discussion about contraception and the ability to provide all forms of contraception (or refer on if not available), is a crucial component of termination services. I am unclear why the guideline developers have gone for such a soft term when lines 12-18 on page 51 stress the importance of contraception. Further, our College endorsed the recommendations in the FSRH post pregnancy contraception guidance that emphasised the importance of the contraception discussion.	Thank you for your comment. The committee agreed that it would not be appropriate to provide all women with information about contraception, particularly in the context of women having an abortion for fetal anomaly, and that a conversation should be had with women to explore if they did require this information. There was also evidence that women thought the way information about contraception had been delivered was too 'pushy'.
Royal College of Obstetricians and Gynaecologists	Guideline	12	16 - 17	The word handling to me refers to the physical touching of the fetal remains. I think the intent here is to discuss disposal/placement of fetal remains	Thank you for your comment. The wording has been amended to 'management and disposal of pregnancy remains' to be consistent with language used by the Human Tissue Authority.
Royal College of Obstetricians and Gynaecologists	Guideline	15	1 - 3	For how long?	Thank you for your comment. As no evidence was identified for this review question it was not possible to specify for how much longer this may be needed. This is explained in the rationale.
Royal College of Obstetricians and Gynaecologists	Guideline	16	5 - 7	Medical termination at home before 10+1 weeks could be the title without the use of the word expulsion. Expulsion does not appear anywhere else, especially not in the decision aid	Thank you for your comment. The term 'expulsion at home' is specifically used here as the evidence reviewed was about the safety of home expulsion specifically, and should not be confused with where misoprostol can be taken, which is specified in the 2018 Secretary of State approval order. The evidence for home use of misoprostol was not reviewed as part of this guideline as it was not legal in England when the protocols for this guideline were developed. Therefore, the

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					committee agreed that the title should not be amended. These recommendations have been amended to clarify that women up to 9+6 weeks gestation can take the misoprostol at home (or in clinic/hospital) and expel the pregnancy at home but women at 10+0 will have to take the misoprostol in clinic before expelling the pregnancy at home.
Royal College of Obstetricians and Gynaecologists	Guideline	19	1 - 3	The advantages of fewer visits with mife/miso same day plus contraception etc are ameliorated by the use of osmotic dilators with cannot be placed by the women herself at home	Thank you for your comment. On reflection, and in response to comments from stakeholders the committee agreed that: 1) between 14+0 weeks and 16+0 weeks, clinicians should consider using osmotic dilators, mifepristone or misoprostol; 2) between 16+1 and 19+0 weeks clinicians should consider using osmotic dilators of misoprostol and 3) to offer osmotic dilators from 19+1 weeks, as there was no evidence to recommend an alternative after this time point. The committee recommended that overnight dilators are considered, not that they have to be used. The committee discussed the impact of overnight dilators on both women and services and that this may not always be possible. The rationale and the committee discussion in evidence report M have been updated to reflect these changes.
Royal College of Obstetricians and Gynaecologists	Guideline	19	14 - 15	In the second bullet point it is not clear when the misoprostol should be administered	Thank you for your comment. There was not enough evidence to specify the interval between misoprostol and abortion, as there was no direct comparison between different intervals and the interval used in included studies ranged from 1 hour to greater than 6 hours. This information is included in the committee discussion in evidence

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					report M. The rationale and impact section for cervical priming between 14+0 and 23+6 weeks has been amended to clarify there was not enough evidence to recommend either dose or timing of misoprostol.
Royal College of Obstetricians and Gynaecologists	Guideline	20	14 - 15	Does this imply the women should be given a multi-level pregnancy test by the service provider? I think it would be better and safer than the women purchasing one herself with potential to interpret incorrectly	Thank you for your comment. The wording of this recommendation has been revised to "Provide women with a low sensitivity or multi-level urine pregnancy test to exclude an ongoing pregnancy" to improve clarity.
Royal College of Obstetricians and Gynaecologists	Guideline	21	23	As soon as possible after medical. How soon is possible? As soon as safely possible – this needs to have a minimum timeframe (suggest 1 week) and presumably the additional risk decays with time from the completion of the procedure	Thank you for your comment. The timeframe specified for insertion of intrauterine contraception (i.e., as soon as possible after the expulsion of the pregnancy) is in line with the evidence reviewed for this question, which confirms that it is safe to insert it straightaway (see also Evidence Report P).
Royal College of Obstetricians and Gynaecologists	Guideline	21	7	The contraception ring is not mentioned.	Thank you for your comment. Vaginal rings are included in recommendation 1.15.1 in the list of the full range of contraceptive options that should be available on the day of the termination.
Royal College of Obstetricians and Gynaecologists	Guideline	42	11	"36-38" Is this a typo and means 36-48 hours?	Thank you for your comment. We can confirm that 36-38 hours is correct, as detailed in evidence report J.
Royal College of Obstetricians and Gynaecologists	Guideline	53	3	Suggest the word termination is replaced with "abortion" to mirror the use of the term "abortion" in the following line.	Thank you for your comment. In response to stakeholder comments, termination of pregnancy has been amended to abortion throughout the guideline.
Royal Devon and Exeter Foundation Trust	Guideline	13		With respect to antibiotic prophylaxis: We welcome the recommendation that Metronidazole not be offered routinely. We also welcome the recommendation that Doxycycline only be given to	Thank you for your comment. In response to stakeholder comments, the recommendations for antibiotic prophylaxis for medical abortion have been amended to say they should not be routinely

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				women undergoing MTOP if they are of higher risk of having Chlamydia. This seems sensible and pragmatic. We have moved away from using any antibiotics for women undergoing medical and surgical management of miscarriage as the evidence, and national/international recommendations no longer support their use. We see hardly any infections as a consequence. It is hard understand why women having surgical termination are a different group. We would ask that you reconsider this point and recommend that antibiotic prophylaxis, for both MTOP and STOP, be reserved for those women with risk factors in their sexual history.	given rather than given to those at risk of STIs as evidence on STI risk was not reviewed as part of this guideline so this population could not be defined. However, the committee agreed that prophylaxis may be appropriate for high risk women or those who would find it difficult to access treatment at a later date in response to a positive screen for sexually transmitted infections. The committee discussion in evidence report D and the rationale and impact has been updated to reflect these changes. There is good evidence from a Cochrane review (Low 2012) that antibiotic prophylaxis for surgical abortion reduced post-abortion infection. Therefore, the committee agreed that routine antibiotic prophylaxis should be given to this group. Indirect evidence from populations of women not having an abortion (e.g., miscarriage) was not included in this guideline.
Royal Devon and Exeter Foundation Trust	Guideline	13		With respect to anti D prophylaxis. We welcome the change in guidance for women having MTOP. We believe there is no real chance of fetal cells accessing the maternal immune system before 12 weeks. This is the gestational limit above which we would consider Anti D for medical management of miscarriage in Rh –ve women. Again it seems illogical to have different gestational limits for women undergoing termination and management of miscarriage. We do support continuing to use Anti for Rh-ve women having surgical termination.	Thank you for your comment. Indirect evidence from populations of women not having an abortion (e.g., miscarriage) was not included in this guideline. Given the absence of evidence and that the benefits of anti-D under 10 weeks have not been demonstrated, the committee decided to align the gestational limit for anti-D prophylaxis for medical abortion with the limits for early medical abortion with expulsion at home. This information is also detailed in Evidence Report C.

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Society for the Protection of Unborn Children (SPUC)	Guideline	General	General	Although not expressly articulated, the *Guideline* makes a clear and highly significant moral statement about abortion. By its stated intention to make abortion as easy as possible to access, the *Guideline* implicitly suggests that abortion is good for women, despite many women's experience to the contrary. It also either implicitly conveys the notion that abortion does not involve the intentional termination of the life of an innocent human being; or alternatively, that innocent human lives may be justifiably terminated on the request of another, older human being. If the former, then the *Guideline* dehumanises the unborn child. But this is unsustainable on scientific grounds as much as on philosophical grounds. The developing human being is on a continuum of development from conception, is genetically unique, and is self-organising – all characteristics pertaining to an individual human life. Furthermore, philosophers often reject the various dualisms that divide a human being into supposedly self-standing parts. The child in the womb cannot be half-human or potentially human, just as no human being can. If the latter position is taken re one life 'trumping' another, how can one innocent human life be justifiably ended at the request of another human being? Setting such a principle in place is deadly and unsustainable – what if it were to be formally applied in other contexts? In abortion this idea is deeply utilitarian and sees the cost of a human life	Thank you for your comments. The Department of Health and Social Care asked NICE to develop a guideline on abortion care. The purpose of the guideline, and improving access to services, is to ensure that abortions are conducted under the safest circumstances possible.

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				as a justifiable price to pay for perceived benefits, however hypothetical, to another human being. The central moral question about abortion, despite the abortion culture that has developed and been promoted over the past 50 years or so, *will not go away*. Surely, at the very least, the *Guideline* should seek to *discourage* abortion, not *encourage* it. Most women do not see abortion as a desirable experience. Most people, regardless of moral persuasion, want to minimise the number of abortions, not maximize them. Even if abortion is seen by some as a sad necessity in some cases, should such cases not at least be minimized? As it stands, the *Guideline* is at risk of promoting abortion as a social good.	
Society for the Protection of Unborn Children (SPUC)	Guideline	General	General	The Guidance makes no mention of foetal sentience, and yet there is anecdotal evidence that women might want to know whether an abortion may cause pain to her unborn child. This is clearly a sensitive area, but one about which a health professional should be able to provide an answer. Despite assurances from some medical bodies that a foetus before 24 weeks cannot experience pain because the cortex is not fully developed, recent research has questioned this. In 2016, Sekulic *et al.* came to the conclusion that "… it could be proposed that the fetus is exposed to rudimentary painful stimuli starting from the 15th gestation week and that it is extremely sensitive to painful stimuli."	Thank you for your comments. The Department of Health and Social Care asked NICE to develop a guideline on abortion care. The purpose of the guideline, is to ensure that abortions are conducted under the safest circumstances possible, not to consider broader ethical issues around abortion.

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				(Sekulic S et al (2016) Appearance of fetal pain could be associated with maturation of the mesodiencephalic structures. *J Pain Res* 9:1031-1038.) There has previously been considerable debate about foetal sentience, and there is an inherent difficulty in providing a definitive answer. But it is possible, and perhaps likely, that pain could be experienced even earlier than 15 weeks. Because of residual uncertainty, on precautionary grounds alone, and given the gravity of potentially causing serious pain to another human being, health professionals should make these possibilities known to women. Bland reassurances will not suffice.	
Society for the Protection of Unborn Children (SPUC)	Guideline	4	9	Allowing women to self-refer for abortion will remove an important opportunity for a health professional to assist with advice, evidence provision, referral for counseling if requested, and the exploration of any suggestion that a woman may be under coercion. Such advice, referral and exploration is not best left to abortion providers, who have a financial conflict of interest. In a recent UK ComRes poll (May 2017), 77% of respondents wanted doctors to be required to verify that there was no pressure from a third party to abort. ([1] See https://www.comresglobal.com/wp-content/uploads/2017/05/Where-Do-They-Stand-Abortion-Survey-Data-Tables.pdf; accessed 30 Jan 2019.)	Thank you for your comment. Recommendation 1.1.2 says women should be allowed to self-refer to services. This recommendation was made in response to evidence that there can be delays getting GP appointments, that physicians can obstruct access to abortions and that women are seen quicker if they self-refer compared to if they are referred by a healthcare professional. However, this recommendation is not prioritising self-referral over a consultation with, and referral from, a GP and this option is still available for women who would prefer this. Self-referral also does not preclude the option of independent counselling. For those women who do choose to self-refer, it would be the responsibility of the abortion service to determine if there are any

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				The public therefore appear to be aware that a problem with coercion exists. This is backed up by plenty of research that shows not only that women have been pressured, coerced and sometimes forced to have an abortion, but that there is a strong link between abortion and intimate partner violence. (See for example: Pallitto CC, García-Moreno C, Jansen HAFM, Heise L, Ellsberg M & Watts C (2013) Intimate partner violence, abortion, and unintended pregnancy: results from the WHO Multi-country Study on Women's Health and Domestic Violence. *Int J Gynecology Obstetrics* 120:3-9; and: Wokoma TT, Jampala M, Bexhell H, Guthrie K & Lindow S (2014) A comparative study of the prevalence of domestic violence in women requesting a termination of pregnancy and those attending an antenatal clinic. *BJOG* 121:627-633.) It is surprising that the *Guideline* only makes mention of coercion in the context of coercion *not to abort*, when by far the majority of evidence is the other way around, namely concerning *coercion to abort*. The *Guideline* needs to consider the literature on the reasons why women have abortions, with particular reference to the links with intimate partner violence. The *Guideline* should then recommend that health professionals seek to ascertain whether such coercion exists and find ways to enable a woman who wants to keep her child to do so free from such threats – for example by alerting social services.	concerns about coercion. This is a duty of care regardless of the medical procedure in question and the General Medical Council (https://www.gmc-uk.org/ethical-guidance/ethical-hub/adult-safeguarding) provides guidance about this. The guideline mentions the threat of violence if partners or families knew a women was having an abortion as this emerged as a theme from the qualitative review in evidence report A. However, there was not a review question about decisions to have an abortion in this guideline. Therefore, the committee cannot make additional recommendations about coercion.

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				Recommending that women self-refer for abortion is a mistake that will likely result in ongoing harm to some women, as well as regret on the part of others for aborting a wanted child.	
Society for the Protection of Unborn Children (SPUC)	Guideline	4	11	If conscientious objection to abortion is to be honoured, and it must, it is impossible to guarantee that some delay in access may not result. A health professional with a conscientious objection to abortion must be free *not* to participate in the chain of events leading to an abortion. By comparison, it is illegal to aid or abet a suicide, in recognition of the moral wrong of helping someone take their own life. Is it so different that, in the view of a doctor with a conscientious objection to abortion, any requirement to aid and abet the killing of an innocent unborn human being is also seen as unconscionable? Whilst this recommendation is not explicit about strategies to avoid delay, any inference that this may entail a requirement to refer to a known provider of abortion must be rejected. There is no need for this recommendation – it appears its sole purpose is to pressure those with a conscientious objection to find a way to ensure and even speed up access to abortion: something they sincerely believe is not in the woman's best interests, any more than those of her unborn child.	Thank you for your comment. This recommendation is consistent with professional guidance (e.g., the General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice) as healthcare professionals have a right to their personal beliefs and to opt out of performing a procedure, but cannot opt out of providing access. Additional information has been added to the rationale to clarify this. Recommendations 1.1.1 and 1.1.2 make it possible for a GP, should they have a conscientious objection, to give the patient information on how to self-refer and therefore not lead to a delay.
Society for the Protection of Unborn Children (SPUC)	Guideline	4	13	The recommendation to provide upfront funding and accommodation to women seeking an abortion will almost certainly encourage some ambivalent women to have an abortion when they may	Thank you for your comment. There is evidence (Cameron 2013) that the majority of women are sure about their decision to proceed at the point of requesting an abortion. Therefore, the

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				otherwise not have done so (ambivalence about abortion is common, and this is well-established – see for example Törnbom M, Ingelhammar E, Lilja H, Svanberg B & Möller A (1999) Decision-making about unwanted pregnancy. *Acta Obstetricia et Gynecologica Scandinavica* 78:636-641). However, there is a justice question here as well. Abortion is a choice that for the overwhelming majority of cases does not correspond to any healthcare need. Why is it being singled out for especially advantageous treatment when there are a plethora of health problems that do not get such attention and support? Women who have a problem with a health issue cannot always access the Travel Scheme, and neither can women who live remotely always get the healthcare they need without having to travel at their own cost. And yet the Guidance is recommending that a procedure that terminates a natural and healthy process should be subsidized. To provide special assistance to obtain an abortion is not only an example of a failure of distributive justice, but also another example of the *Guideline's* recommendation resulting in the encouragement of abortion. Would it not be a good thing to instead encourage bringing a child to birth? Should woman not be given information on charities that will support them, accommodation they can live in, travel support to access such accommodation, etc?	recommendations in this guideline aim to reduce unnecessary delays once a women has requested an abortion. As this guideline covers abortion care, it is only within the scope of this guideline to make recommendations about funding for travel and accommodation for abortion care, not for other areas of healthcare. However, abortion is rather unique in terms of having a time limit during which the procedure can be performed and women often have to travel at very short notice compared with women having treatment for other conditions that may have several weeks' notice before an appointment. It was not within the scope of this guideline to make recommendations for women who decide to continue with pregnancy.

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Society for the Protection of Unborn Children (SPUC)	Guideline	5	4	Abortion is not like any standard medical procedure. It has always been widely debated, subject to specific legislation, and viewed as a serious question of morals and ethics. There are few medical procedures that raise such scrutiny and about which large sections of the community hold quite divergent views. Because of this, and the gravity of what abortion actually does and can mean for a woman, a case can be made for mandatory counseling or at least, the offer of such counseling independent of any abortion provider during a mandatory period for consideration. Such counseling can be provided sensitively and with respect for a woman's existing knowledge and awareness of issues related to abortion. A recommendation should be made to the effect that individual health professionals may refer a woman for counseling before proceeding with a termination, and that at least in these cases, until a certain period has expired, the abortion cannot take place. Because ambivalence is common, there should be a period of time set in place to help all matters to be taken into account before an abortion can take place. There is plenty of research about abortion regret, so this is an important matter. As it is, time for consideration is built into legislation when someone wishes to purchase a house or land. Surely, time allocated for considering the irreversible, life-changing and life-ending decision of abortion should be at least as generous?	Thank you for your comment. The law does not stipulate an enforced waiting time or counselling, and it is beyond the remit of NICE guidance to amend legislation. There is evidence (Cameron 2013), however that most women (93%) are certain of their decision to not continue a pregnancy at the point at which they request an abortion. Therefore, once a women has requested an abortion she should not be faced with unnecessary delays due to the organisation of services. However, recommendation 1.1.7 was included to ensure that women can wait longer to have an abortion if they would prefer this for whatever reason, including if she is still considering her options. Recommendation 1.1.8 has also been amended to say women should be provided with, or referred to support to make a decision if they request this. The rationale has been expanded to clarify this.

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Society for the Protection of Unborn Children (SPUC)	Guideline	7	3	The Guidance seeks to reassure women considering an abortion that there is no increased risk of breast cancer as a result of an abortion. Clearly this is an area of research with a history of dispute. However, what is uncontroversial is that carrying a child to term is protective against breast cancer. (see for example, Russo IH & Russo J (2011) Pregnancy-induced changes in breast cancer risk. *Journal of Mammary Gland Biology and Neoplasia* 16(3):221-33.) Therefore, if a woman presenting to a health professional were to ask what an abortion might mean for her breast cancer risk, an accurate reply should be something like, "if you carry this child to term you will have a lower risk of breast cancer than if you have the abortion." To deny women this critical piece of information is to deny them the opportunity for fully informed consent. Moreover, a woman should not have to ask about her breast cancer risk being lower if she carries to term – the information should be provided proactively by the health professional she consults (in the particular context of seeking informed consent, this can even be the health professional's legal duty).	Thank you for your comment. The American College of Obstetricians and Gynecologists concluded that the early studies on the relationship between induced abortion and breast cancer were flawed and that more rigorous, recent studies with prospective designs showed no causal relationship. Therefore, the committee agreed that there is no evidence of a link between having an abortion and increased risk of breast cancer and agreed women should be informed of this. The focus of this guideline is women having an abortion, not continuing pregnancy to term; therefore, benefits and risks associated with continuing a pregnancy was not considered as part of this guideline. However, there are risks associated with continuing a pregnancy to term and giving birth (e.g., urinary and bowel incontinence, prolapse) that may outweigh potential reductions in breast cancer risk.
Society for the Protection of Unborn Children (SPUC)	Guideline	7	3	The *Guideline* states that abortion confers no risk to fertility. However, the NHS advises that there is a risk that abortion can lead to untreated infection, which in turn can lead to Pelvic Inflammatory Disease (PID).	Thank you for your comment. The committee agree that it is necessary to fully inform women of risk associated with having an abortion but have not made exhaustive recommendations about this as it is part of good clinical practice. The

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				About 1 in 10 women with PID become infertile, and also have an increased risk of ectopic pregnancy, a life-threatening condition. (See https://www.nhs.uk/common-health-questions/womens-health/can-having-an-abortion-affect-my-fertility/ Accessed 9 May 2019). The advice is explicit that abortion is a risk factor for PID. The NHS places risk of infection after abortion at 10%, and notes that antibiotics are usually effective – the clear implication being, not always. See https://www.nhs.uk/conditions/abortion/risks/ Accessed 9 May 2019). In a recent study by Wang and colleagues, women with a history of induced abortion had poorer outcomes in IVF treatment. Prior abortion was associated with a higher miscarriage rate, a lower clinical pregnancy rate and a lower live birth rate. The endometrium was also significantly thinner in women with a history of abortion. (Wang Y *et al.* (2018) Association between induced abortion history and later in vitro fertilization outcomes. *Int J Gynecol Obstet* 141:321-326). Hence, the risk to future fertility needs to be included when seeking informed consent. It is important to note that in the UK the standard for informed consent has been redefined by Montgomery *v* Lanarkshire. In this landmark case, the standard for deciding about disclosure of a risk shifted from the "reasonable doctor" to the "reasonable patient", meaning that a risk that the *patient* considers significant is what counts, not	introductory text has been amended to remind healthcare professionals to provide information and obtain informed consent in line with guidance General Medical Council (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent) guidance and the 2015 Montgomery ruling. The evidence for long-term health risks was not formally reviewed as part of this guideline. However, the committee agreed that a recommendation should be included that reassures women there is no increased risk of infertility, breast cancer and mental health problems as these are frequently mentioned despite the best available evidence showing that is not the case. Whilst the NHS does recognise risk of PID, it also makes the statement that 'Having an abortion won't affect your chances of becoming pregnant and having normal pregnancies in the future' which is supported by recommendations from the RCOG that women can be reassured that there are no proven associations between abortion and infertility. It is the committees' experience that most women, if they know what to look for, will present with signs of infection and get treatment before PID develops and recommendations 1.2.9 and 1.14.3 cover giving women advice about potential complications.

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				what a *doctor* might think. (See https://www.medicalprotection.org/uk/articles/new-judgment-on-patient-consent Accessed 9 May 2019). This standard already applied in Australia after Rogers v Whitaker. In this case the doctor did not disclose a 1 in 14,000 risk of blindness from an operation the patient underwent. Blindness resulted, and the outcome of the subsequent case set the standard in Australia for what risks must be disclosed. The point of mentioning the above is that even if the risk of infertility from abortion is small, women may attach a high level of significance to it and decide against abortion. Women need to be told – and the *Guideline* must reflect this.	
Society for the Protection of Unborn Children (SPUC)	Guideline	7	4	The link between abortion and adverse mental health outcomes is one that has attracted much attention from researchers, and about which much more needs to be explored. There are strong grounds to acknowledge that aspects of this risk are not settled, and yet certain medical bodies have rushed to reassure women that abortion will have no adverse effect upon their mental health. This position is inaccurate, on some counts dishonest, and could potentially lead in the future to legal claims against those medical bodies. Amongst many others, researchers like Sullins, Fergusson, Coleman, and very recently Jacob, have all found clear associations between abortion and adverse mental health outcomes, some of	Thank you for your comment. The committee agree that it is necessary to fully inform women of risk associated with having an abortion but have not made exhaustive recommendations about this as it is part of good clinical practice and covered by professional guidance (e.g., General Medical Council https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent). The evidence for long-term health risks was not formally reviewed as part of this guideline. However, the committee agreed that a recommendation should be included that reassures women there is no increased risk of infertility, breast cancer and mental health problems as these are frequently mentioned

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				them being convinced the relationship is causative. (Sullins DP (2016) Abortion, substance abuse and mental health in early adulthood: Thirteen-year longitudinal evidence from the United States. *SAGE Open Med* 4:1-11; Fergusson DM *et al.* (2006) Abortion in young women and subsequent mental health. *J Child Psychol & Psychiatry* 47(1):16-24; Coleman PK (2011) Abortion and mental health: quantitative synthesis and analysis of research published 1995-2009. *Brit J Psychiatry* 199(03):180-186; Jacob L *et al.* (2019) Association between induced abortion, spontaneous abortion, and infertility respectively and the risk of psychiatric disorders in 57,770 women followed in gynecological practices in Germany. *J Affective Disorders* 251 (2019) 107–113). Research from the Turnaway study has made strong and definitive claims to the contrary, as has Munk-Olsen's group. However, the flaws in these studies are so palpable (particularly in the Turnaway Study), that they seem primarily to have muddied, if not misled, the field. One important observation is that negative and troubling emotions experienced by most women, sometimes decades after their abortion(s), may not rise above the threshold to be classified as adverse mental health outcomes. They remain disturbing and potentially damaging, yet have been discounted. Moreover, there may be multiple factors that contribute to negative emotional responses, as well as adverse mental health outcomes, abortion being just one. But it does not	despite the best available evidence showing that is not the case. The committee were aware that the Academy of Medical Royal Colleges guidance showed that following an unwanted pregnancy, there was not an increased risk of having mental health problems in women who had an abortion compared with those who have birth. The Ferguson review cited did not control for pre-existing mental health problems, which are more likely to occur again irrespective of whether a woman has an abortion. Further, the Ferguson review acknowledges that comparing women with an unwanted pregnancy that had an abortion with women with an unwanted pregnancy that decided to continue to term may not be the appropriate comparison. They said a more appropriate comparison may be to compare against women with an unwanted pregnancy who were refused an abortion. They were only aware of one study that did this (Gilchrist 1995), but this study showed a higher rate of psychotic illness in women refused an abortion. Therefore, the committee concluded that there was no robust evidence of a link between abortion and mental health problems.

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				have to be the *sole* factor to be relevant when deciding on what information the woman needs. Much stronger (and agreed upon) evidence exists for adverse mental health impact when there are multiple abortions, or abortions for reasons of foetal anomaly. Why does the *Guideline* not recommend that this evidence be conveyed to women by doctors they consult regarding their pregnancies? Furthermore, almost all researchers recognise the importance of predisposing risk factors for adverse mental health outcomes after abortion. Why should women with such risk factors, for example pre-existing poor mental health, not be properly informed about their risk? In summary, the *Guideline* is deficient about this issue, and by not properly informing health professionals about the risks, ends up doing them and the women they seek to help, a serious disservice.	
Society for the Protection of Unborn Children (SPUC)	Guideline	7	10	The rate of effectiveness of medical abortion in the first trimester using Mifepristone/Misoprostol is around the 95% mark, but in a real-world setting is likely to be lower as this figure comes from studies in controlled research environments (Raymond EG *et al.* (2013) First-trimester medical abortion with mifepristone 200 mg and misoprostol: a systematic review. *Contraception* 87:26-37). Moreover, most of the studies in the review were for less than 9 weeks gestation, later gestations entailing lower effectiveness, and medical abortion in the second trimester having lower rates of effectiveness still.	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA does not include the wording you refer to.

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				Furthermore, taking a regime of Mifepristone/Misoprostol outside of a clinic setting increases the risk of incomplete abortion. It would not be unrealistic to expect that around 1 in 10 women who have a medical abortion would return for follow up surgery. This does not translate to medical abortion being "highly effective".	
Society for the Protection of Unborn Children (SPUC)	Guideline	10 left column & 11	5	The *Guideline* minimises the side-effects of medical abortion prior to 13 weeks, as well as the serious risks. It tries to reassure women that abortion is "highly safe" (page 7, line 10). Women should be informed that a medical abortion is accompanied by the following side-effects: nausea (30.7 - 69.2%), vomiting (22.3 - 34.1%), diarrhea (31.8 - 58.6%), pain (91.6%), fever (21.3 – 44.3%), chills (36.5 – 44.3%), headache (12.3 – 42%), dizziness (13.1 – 45.5%), and weakness (19.2 – 56.6%) (Mifegymiso Product Monograph, 2016). 40-60% of women have reported the pain of medical abortion as severe (Dahiya K *et al.* (2012) Efficacy and safety of mifepristone and buccal misoprostol versus buccal misoprostol alone for medical abortion. *Arch Gynecol Obstet* 285:1055–1058). These figures suggest that very unpleasant side-effects are very common during a medical abortion. The *Guideline* states that less than 0.1% of women will have severe bleeding or sepsis. However, in a recent study by Winikoff and associates, between 1.0% and 1.2% of women had	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The PDA has been developed in collaboration with patient representatives and specialists. The NICE guideline did not review the evidence comparing surgical and medical <13 weeks, and national statistics were used in lieu of an evidence review. Text has been added to the PDA to clarify where the data is taken from. The limitations of the national statistics were noted by the specialists, but it was agreed that it was not appropriate to report data from single studies when the evidence has not been reviewed.

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				'excessive prolonged bleeding', and between 0.3% and 0.6% required a transfusion (Winikoff B *et al.* (2012) Extending Outpatient Medical Abortion Services Through 70 Days of Gestational Age. *Obstet Gynecol* 120:1070–76). Moreover, this was for gestational ages up to 10 weeks; up to 13 weeks the situation would be expected to be worse. This study is not alone; there are others reporting rates of transfusion higher than 0.1% (for up to 9 weeks). Furthermore, as the Winikoff data reveals, rates of 'severe bleeding' will be higher than those for transfusion, depending on how severe bleeding is defined. But whatever the case, severe bleeding is a medical emergency. When it comes to infection, sepsis is a severe result, but even treated infection, as noted earlier, can result in PID and the risk of infertility. Women should be told the overall risk of infection and that there is a risk it will resist treatment. Carlsson and colleagues recently found that "Of all women who tested positive for one or several bacteria at the screening and therefore received antibiotics, 1.4% developed a postabortal infection. Among those who tested negative at the screening, 1.7% developed infectious complications."(Carlsson I *et al.* (2018) Complications related to induced abortion: a combined retrospective and longitudinal follow-up study. *BMC Women's Health* 18:158). This finding not only points to a significant risk of infection from medical abortion, but also that treating infection can be difficult.	

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				Rather than being simply assured that abortion is "highly safe", women should instead be informed in detail about what they should expect to experience and about the full complement of risks.	
Society for the Protection of Unborn Children (SPUC)	Guideline	15	10 - 12	The *Guideline* recommends that abortion be considered before there is definitive ultrasound evidence of an intrauterine pregnancy (when there are no signs or symptoms of an ectopic pregnancy). Doing so will risk missing an ectopic pregnancy, the consequences of which are very serious and include the risk of death. The *Guideline* makes this recommendation even though there is (very limited) evidence from just 3 studies of "very low quality" about the increased risk that is expected to occur (Evidence review [F] on Termination of pregnancy before ultrasound evidence). The key reason for accepting the risk appears to be to speed up the whole process: > The committee also agreed to prioritise patient satisfaction as a critical outcome for decision-making as termination of pregnancy is an area where women are known to have strong preferences for prompt resolution. (Evidence Review F page 10, lines 36-38) To mitigate the risk, the *Guideline* notes that services will need to have in place "systems to confirm that a pregnancy has been aspirated", and "staff trained to inspect the products of conception".	Thank you for your comment. As outlined in Evidence report F, the risk of ectopic pregnancy is lower in women undergoing abortion than in the general population of women, which means it is very low. Further, the evidence review did not show any increased risks associated with performing an abortion before definitive ultrasound evidence. However, the committee discussed the risk of a missed ectopic pregnancy and reflected this in the strength of recommendation 1.7.1 and the inclusion of recommendation 1.7.2, which covers explaining this risk to women, methods to identify an ectopic pregnancy, and the potential need for follow-up, which would be applicable when the success of an abortion cannot immediately be ascertained (such as through the inspection of chorionic villi). Recommendations 1.14.1 and 1.14.2 cover follow-up of women who have early medical termination, outlining that a pregnancy test should be provided to exclude ongoing pregnancy, not home inspection of the expelled products of conception. Having included these recommendations to minimise the risk of an undiagnosed ectopic pregnancy, the committee agreed that the recommendation 1.7.1 will reduce unnecessary delays due to services requiring ultrasound confirmation and result in safer

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				But more and more abortions are medical and the *Guideline* recommends expulsion at home, where no such services exist. Are women to be expected to conduct such inspections themselves? The outcome of this recommendation, ostensibly on the grounds of patient satisfaction, is to place at risk the lives of women who may – for reasons currently unidentified, and on the basis of lack of evidence – be at risk of ectopic pregnancy. Such women will be all the more at risk because the *Guideline* recommends they abort at home, possibly alone.	abortion care as the risks of abortion increase with increasing gestations (see evidence review A).
Society for the Protection of Unborn Children (SPUC)	Guideline	23	15	There is insufficient research on abortion and mental health, particularly with regard to identifying those women who will be most at risk of adverse outcomes. There is insufficient research on the relationship between abortion and infertility. Given the acknowledged link between abortion, infection (even with prophylactic antibiotics) and PID, and the acknowledged link between PID and infertility, the risk of infertility as a result of abortion needs to be further explored. A significant amount of the research on medical abortion is being conducted by researchers either with links to abortion providers, or who are members of advocacy groups for the expansion of access to abortion. Research funding should be directed to researchers without such links.	Thank you for your comments. NICE guidelines are only able to make research recommendations if an evidence review is conducted but limited or no evidence is identified by the searches. Therefore, it is not possible to make research recommendations in the areas you have suggested as the guideline did not include review questions in those areas.

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Society for the Protection of Unborn Children (SPUC)	Guideline	27	11	The suggestion that improving access to abortion services will save money is entirely speculative. One might just as well argue that *restricting* access to abortion services will result in less abortions, more births, less adverse (and costly) outcomes for women, and an increase in total societal wealth through contributing more workers and tax-payers. The argument is biased and should be removed.	Thank you for your comment. This was based on economic modelling undertaken in evidence report A, appendix J. Assumptions made, included and excluded costs, perspective and weaknesses are discussed in detail there. The text has been updated in the main guideline to highlight that cost savings are only based around procedure costs and reduction in adverse events.
Society for the Protection of Unborn Children (SPUC)	Guideline	34	23	A reduction in the number of women having antibiotic prophylaxis for a medical abortion is a significant risk that the *Guideline* is recommending in the face of a 'shortage of evidence'. An argument based on cost saving and reduction of risk of antibiotic resistance does not seem to be sufficient to justify the recommendation. The link between infection, PID, and infertility suggests instead that the costs in both financial and human terms of increased infections may be greater than expected, and outstrip the putative savings mentioned.	Thank you for your comment. The committee agreed based on their knowledge and comments from stakeholders, that the risk of antibiotic resistance and not being able to successfully treat infections in the future presents a greater risk than risk of PID following medical abortion as the risk of PID is greatest when instrumentation is introduced into the womb, which does not occur with medical abortion. Further, recommendations 1.2.9 and 1.14.3 cover giving women advice about potential complications and it is the committees' experience that most women, if they know what to look for, will present with signs of infection and get treatment before PID develops. Posited cost savings are a result of recommendations, not the reason for them.
The Down's Syndrome Association	Guideline	1		We fully support the recommendation that people have a right to be involved in discussions and make informed decisions about their care, but we would add into this recommendation the need for specific training for those involved in supporting pregnant women to make personalised informed choices.	Thank you for your comment. The committee agree that it is important to be able to present information in a non-directive way and have made recommendations 1.2.2 in support of this. Whilst the guideline makes recommendations about the principles under which training should be

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				There needs to be a recognition that this is a complex arena, that often requires non-directive counselling skills in the health professionals providing information and support to women in order for them to reach a decision that they feel is right for them. We would cite the excellent resource produced by Dr Louise Bryant, which forms part of the Fetal Anomaly Screening Programme e-learning resource, which is focused on antenatal care professionals supporting women to make personalised, informed, choices about their care.	delivered, the specific content of training is beyond the scope of NICE guidelines.
The Down's Syndrome Association	Guideline	2	4	We would add that women also need information about where they can access support, which might include other options available to them, as well as termination. In the case of a fetal anomaly, (for example) women would also need to know where to access up to date and accurate information about the condition that has been identified in their developing baby in order for them to make an informed choice about whether to continue with their pregnancy or consider a termination. This might include referral to additional organisations such as The Down's Syndrome Association in order to ask questions and gather information.	Thank you for your comment. Recommendation 1.1.8 has been amended to say women should be provided with, or referred to support to make a decision if they request this. However, this guideline does not cover the time between conception and requesting an abortion. In the context of fetal anomaly, it would be the responsibility of the fetal medicine service, not the abortion service, to provide and direct women to information about the condition that has been identified.
The Down's Syndrome Association	Guideline	5	1	This statement implies that waiting has only negative consequences. As termination of a pregnancy is obviously a decision, which cannot be revisited, it is imperative that women feel they	Thank you for your comment. Recommendation 1.1.7 was included to ensure women can wait longer for an abortion if they would prefer this. Recommendation 1.1.8 has been amended to say

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				have reached a decision, which is right for them without being rushed to the decision point. In the case of news about a fetal anomaly, for example, women may need time to digest the news and gather information (from a variety of sources) before they feel ready to make a decision about continuing or ending their pregnancy. This might take an extended period for some women. Counselling or reflection time might not be compulsory, but it should be determined by the needs of each women and appropriate space, time and support provided for as long as is needed.	women should be provided with, or referred to support to make a decision if they request this.
The Down's Syndrome Association	Guideline	12	23	It is imperative that, if women are to make choices which are both personalised and informed, they must be able to access up to date, balanced and accurate information about the anomaly which has been identified in their developing baby. This might be from a variety of sources and could include referral to specialist organisations like The Down's Syndrome Association, who have the expertise and time to provide this up to date information.	Thank you for your comment. The guideline is for people who have requested an abortion and covers safe and effective abortion care. Therefore, information about a fetal anomaly is outside the scope of this guideline. This information should be provided by the maternity service/fetal medicine specialist that diagnosed the anomaly.
The Down's Syndrome Association	Guideline	28	23	We would highlight that midwifery services are already over-stretched and midwives time is highly constrained. Whilst we acknowledge that women may have expressed the view that they wish their care (during and after) a termination to be	Thank you for your comment. We received comments from the Royal College of Midwives during this consultation, which are published in this table.

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				coordinated by midwives, we ask what are the views of midwives about this potential aspect of their role? The views of midwives and their professional bodies gathered through this consultation must be taken into account.	
The Down's Syndrome Association	Guideline	29	7	We would stress that our involvement with Public Health England and Public health Wales in the development of information for women accessing antenatal care and needing up to date and balanced information about fetal anomalies has not been without differences in opinion about what information about the conditions should be included in public-facing information for women. A number of stake-holders, including The Down's Syndrome Association, have expressed concern that the information is overly focused on the potential medical conditions sometimes associated with a fetal anomaly and less on the 'lived-experience' of what raising a child with Down's syndrome might be like. It is our experience that the latter is of more relevance to women making decisions about continuing or terminating their pregnancy.	Thank you for your comment. The guideline is for people who have requested an abortion and covers safe and effective abortion care. Therefore, information about a fetal anomaly and is outside the scope of this guideline. This information should be provided by the maternity service or fetal medicine specialist that diagnosed the anomaly.
The Down's Syndrome Association	Guidance	29	26	We very much agree with this statement and would highlight that, although midwives should be trained to provide up to date and balanced, accurate information about fetal anomalies, this is not always provided in practice. Where appropriate, women should be informed of the	Thank you for your comment. The guideline is for people who have requested an abortion and covers safe and effective abortion care. Therefore, information about a fetal anomaly and is outside the scope of this guideline. This information would normally be provided by the maternity service or

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				additional information available from specialist organisations like The Down's Syndrome Association who have the time and expertise to provide support.	fetal medicine specialist that diagnosed the anomaly.
The Down's Syndrome Association	Guidance	30	3	We would strongly advocate for further research into this important area of women's experience.	Thank you for your comment. There was a lot of evidence for this compared to other areas of the guideline. Therefore, the committee decided not to prioritise it as an area for future research.
The Royal College of Midwives	Guideline	General	General	We welcome the production of this Guidance. We congratulate NICE on pulling together a high quality piece of work. The provision of terminations services must be based around collaboration and integration of care.	Thank you for your comments.
The Royal College of Midwives	Guideline	General	General	'Time to treatment': Whilst we totally support the need to ensure women are not kept waiting, this must be balanced with affording women the right to choose to delay. Services must respond to individual needs and preferences.	Thank you for your comment. Recommendation 1.1.7 is intended to ensure women can have a longer wait if they would prefer this. The rationale for this recommendation has been expanded to acknowledge that some women might want extra time to consider their decision after the assessment.
The Royal College of Midwives	Guideline	4	8	This pathway should be available to all staff so they can refer onwards with accurate and current information on alternative services available.	Thank you for your comments. The committee agree that streamlined services are important, and have made recommendations in section 1.1 to ensure they are. However, how these pathways are delivered are a matter for local implementation.
The Royal College of Midwives	Guideline	4	11	Conscientious objection provisions should be cited here, for clarity.	Thank you for your comment. The management of conscientious objection is the right of all healthcare professionals and is covered by legislation and relevant guidance (e.g. the General Medical Council https://www.gmc-uk.org/ethical-

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					guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice). Therefore, it is not necessary to make additional recommendations relating to it in this guideline.
The Royal College of Midwives	Guideline	4	16	This needs to be advertised so that women are aware that funding is available.	Thank you for your comment. An additional point has been added to this recommendation to say that commissioners should make information about any upfront funding available.
The Royal College of Midwives	Guideline	5	5	We support the removal of compulsory counselling. However, it is important that counselling is always available for those who want it. Information should also include how to access support afterwards and local support groups.	Thank you for your comment. Recommendation 1.1.8 has been amended to say women should be provided with, or referred to support to make a decision if they request this. Support afterwards is covered by recommendations 1.14.3 to 1.14.6.
The Royal College of Midwives	Guideline	5	14	These staff need appropriate training.	Thank you for your comment, the recommendations about the workforce in this guideline should support the commissioning of training that will support services to deliver these recommendations.
The Royal College of Midwives	Guideline	5	22	The clauses for conscientious objection do not allow staff from opting out of all care for women. Therefore, some training will still be required.	Thank you for your comment. The committee agree that conscientious objection does not allow staff to opt out of all care for women. However, the committee agreed that skills required for care for women who have had an abortion (but not the abortion itself) would overlap with training regarding other obstetric and gynaecological procedures, such as management of miscarriage.
The Royal College of Midwives	Guideline	6	24	Services need to provide an environment that will minimise distress and protect dignity. I.e. a dedicated ward area, with well-trained staff, and privacy where the pregnancy can be passed.	Thank you for your comment. The committee agree that the environment should minimise distress and protect dignity but did not make recommendations about separating these groups as the evidence on how effective this would be at reducing distress was not reviewed by the

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					committee, there might not be the resources to support separate clinics in rural areas and maternity wards may be the safest place for women having a late termination, and separating women can be stigmatising and may make them easier to identify as having an abortion. Additional information has been added to the rationale and the committee discussion in evidence report A to address these issues and concerns.
The Royal College of Midwives	Guideline	7	1	National support groups provide a range of resources to support parents and staff. Access to these should be widely available and staff should be familiar with these to be able to refer on appropriately.	Thank you for your comment, recommendations 1.1.1 and 1.14.4 relate to information about services, and information about support groups. There will also be a list of relevant organisations/materials available on the NICE website 'Abortion pages' when the guideline is published.
The Royal College of Midwives	Guideline	8 (inside the box)	12	'Information relating to surgical procedures' – we suggest adding that women should be counselled that surgical termination is a destructive process so there may be little identifiable tissue to see.	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. The committee decided that the current wording gave sufficient detail as women are advised that, with surgical abortion, they will not normally see the pregnancy unless they choose to do so. If a women does express that they would like to see the pregnancy, clinicians should discuss with women whether there is likely to be identifiable tissue.
The Royal College of Midwives	Guideline	9 (inside the box)		'Follow up information' – There should be a mechanism for follow up for those who want or need physiological support, as per existing miscarriage guidance.	Thank you for your comment. Table 1 has been replaced by a patient decision aid (PDA) that will be published at the same time as the guideline. Follow-up in the table is referring only to routine follow-up required to exclude ongoing pregnancy.

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					Psychological support is covered under recommendations 1.14.4 to 1.14.6. This is not included in the PDA as the recommendations do not differ based on type of abortion.
The Royal College of Midwives	Guideline	11	4	Suggest also adding: where and who they will be cared for by; what the remains may look like; psychological impact; what follow-up services are available.	Thank you for your comment, recommendations 1.2.3, 1.2.7, and 1.14.1-5 cover the points you have raised.
The Royal College of Midwives	Guideline	12	10	Add 'what will happen to the remains'.	Thank you for your comment. This is covered by recommendation 1.2.10.
The Royal College of Midwives	Guideline	12	17	Suggest this needs some specific guidance about disposal of human tissue as per the HTA guidance.	Thank you for your comment. A reference to the Human Tissue Authority guidance has been added to the rationale but it is beyond the scope of this guideline to provide specific guidance on this. This is explained in the committee discussion in evidence report B but has been added to the rationale for clarity.
The Royal College of Midwives	Guideline	12	23	Women should have all the information available about the anomaly, its severity, impact, and possible short and long term outcomes should the pregnancy continue.	Thank you for your comment. The guideline is for people who have requested an abortion and covers safe and effective abortion care. Therefore, information about a fetal anomaly is outside the scope of this guideline. This information should be provided by the maternity service or fetal medicine specialist that diagnosed the anomaly.
The Royal College of Midwives	Guideline	12	25	Careful discussion is required to find out the parents wishes about seeing the baby and what to expect. Discussion also needed about possibilities for memory building, such as photographs, hand and foot prints, lock of hair and the clothing baby is to be dressed in.	Thank you for your comments. As with all NICE guidance, this guideline should be read in conjunction with the NICE guideline on Patient Experience in Adult NHS Services which makes recommendations on knowing the patient as an individual and tailoring healthcare for each patient, and which is cross referenced in recommendation 1.2.5 of this guideline. The guideline is for people

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					who have requested an abortion and covers safe and effective abortion care. Therefore, options for memory building is outside the scope of this guideline.
The Royal College of Midwives	Guideline	17	1	There is acknowledgement in the evidence documents (L) that the offer of feticide is recommended by the RCOG but has not been included in this guideline. It is unclear why such a key recommendation has been left out.	Thank you for your comment. We did not review the evidence for feticide as this was not in the scope of this guideline so the committee were unable to make recommendations in this area. The information in evidence report L has been added to the relevant rationale section to explain why recommendations were not made. This will be highlighted to the NICE surveillance team to be aware of when conducting update searches in the future.
The Royal College of Midwives	Guideline	17	12	Suggest including information that a 48-hour interval gives higher rates of completed termination.	Thank you for your comment. However, this was not supported by the evidence reviewed for this question. The only study that found a significantly higher complete abortion rate after a 2-day interval (relative to a 1-day interval) used additional doses of oral misoprostol, which the committee did not recommend (see also Evidence report J).

None of the stakeholders who comments on this clinical guideline have declared any links to the tobacco industry.