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Experiences and characteristics of women seeking and completing at-home medical termination of pregnancy through online telemedicine in Ireland and Northern Ireland: a population-based analysis

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Abstract

Irish & Northern Irish women completing at-home medical TOP report benefits for health, wellbeing and autonomy

Objective—To examine the characteristics and experiences of women in Ireland and Northern Ireland seeking at-home medical termination of pregnancy (TOP) using online telemedicine.

Design—Population-based study.

Setting—Ireland and Northern Ireland.

Population—Between January 1st 2010 and December 31st 2015, 5,650 women requested at-home medical TOP through online telemedicine initiative Women on Web (WoW).

Methods—We examined the demographics and circumstances of women requesting medical TOP and examined the experiences of the 1,023 women who completed TOP between January 2010 and December 2012. We conducted a content analysis of women's evaluations and used logistic regression to examine factors associated with lack of emotional support during and after TOP

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Contribution to Authorship

ARAA originated the study. ARAA, RG, and JT all contributed to the study design. ARAA conducted the analyses and prepared the tables and figures. ARAA, RG and JT all contributed to the interpretation of results. ARAA wrote the first draft the manuscript. ARAA, RG and JT all contributed to several rounds of manuscript drafting and approved the final manuscript.

Disclosure of Interests

ARAA reports no conflicts of interest. RG is the Founder and Director of Women on Web. JT is a member of the Board of Directors of the Women on Web Foundation. The ICMJE disclosure forms are available as online supporting information.

Details of Ethics Approval

This project was exempt from review by the Institutional Review Board (IRB) at Princeton University on the basis that no identifying data were accessed and all data were pre-existing.

Main Outcome Measures—Satisfaction with TOP; Feelings before and after TOP; Emotional support during TOP

Results—Women requesting TOP were diverse with respect to age, pregnancy circumstances, and reasons for seeking TOP. Among those completing TOP, 97% felt they made the right choice and 98% would recommend it to others in a similar situation. Women commonly reported serious mental stress caused by their pregnancies and their inability to afford travel abroad to access TOP. The feelings women most commonly reported after completing TOP were “relieved” (70%) and “satisfied (36%). Women with financial hardship had twice the risk of lacking emotional support (OR=2.0, p<0.001).

Conclusions—The vast majority of women who completed at-home medical TOP through WoW had a positive experience. These demonstrated benefits to health and wellbeing contribute new evidence to the debate surrounding abortion laws in Ireland and Northern Ireland.

Keywords

Termination of pregnancy; Telemedicine; Ireland; Northern Ireland; Abortion policy; Abortion

Introduction

Abortion laws in the Republic of Ireland (hereafter Ireland) and in Northern Ireland are among the most restrictive in the world.[1] Termination of pregnancy (TOP) is illegal except to save a woman's life, or in Northern Ireland only, to preserve her permanent physical or mental health.[2,3] Yet even these provisions have a murky legal interpretation. Providers, fearing prosecution, rarely implement them.[4,5] Women too face criminal prosecution for carrying out their own TOP or for helping others to do so.[6] In Northern Ireland, the maximum sentence is life imprisonment; the harshest abortion-related criminal penalty in Europe.[7]

For decades, women living in Ireland and Northern Ireland who experience a pregnancy they do not want or do not feel they can continue have had three options: travel abroad to obtain a safe, legal TOP; self-induce using an unsafe method; or remain pregnant. Between 1970 and 2015, 180,797 women from Ireland and 61,311 women from Northern Ireland travelled to access TOP services in Great Britain.[8] While travel is not an easy option[9], it is feasible only for women who can afford air or sea transport and are able to arrange time away from work and family. These barriers create a stark health inequity: women with financial and social resources can access offshore TOP, while women who lack such resources cannot.

Yet since 2001, the number of women traveling to England and Wales to access services has declined.[10] And since 2006, women have had an alternative option: at-home medical TOP provided through online telemedicine. This option costs much less than travel abroad and thus may provide a safe, affordable, accessible pathway for women with the fewest resources. Previous non-governmental organization (NGO) reports have examined the characteristics and experiences of women living in Ireland and Northern Ireland who travel to obtain TOP.[9,11] Yet virtually nothing is known about women who access medical TOP at home. This knowledge gap prevents public health practitioners, policy-makers, and

physicians from understanding and engaging with the realities these women face. Consequently, their experiences are not included in the policy conversations surrounding Irish and Northern Irish abortion laws.

Using data from an online medical TOP telemedicine service, the objectives of this study are to: 1) examine the characteristics of women living in Ireland and Northern Ireland seeking at-home medical TOP; and 2) conduct a rigorous examination of the experiences of these women, both with their pregnancies and with TOP.

Methods

We examined data from Women on Web (WoW), a non-governmental, non-profit organization that provides early medical TOP outside the formal healthcare setting through online telemedicine in areas where safe TOP is not available. Women make a request for medical TOP by filling in a consultation form on the WoW website.[12] Women with a pregnancy of up to nine weeks gestation at the time of request are referred to a WoW doctor. If clinical criteria are met, the woman either makes a donation to support the service or explains that she cannot afford a donation (in which case, the donation amount is reduced or the service is donated to her). The doctor provides a prescription according to the WHO recommended dosage regimen for medical TOP[13], and mifepristone and misoprostol are dispatched by a partner organization. Real-time instruction and follow-up are conducted through email by a multilingual, specially trained helpdesk team.[14] Previous evaluations of the service in Brazil and other settings where abortion is restricted provide evidence for its safety and effectiveness.[14,15] Women who complete TOP are invited to share their experiences using an online evaluation form or via email to the helpdesk.

We retrieved all requests for TOP from women in Ireland and Northern Ireland who filled out an online consultation form between January 2010 and December 2015. Although WoW first began providing online telemedicine TOP in 2006, the service underwent extensive piloting and development over its first four years. Changes to the software used to handle requests mean that data are available from 1st January 2010 onwards only.

In our analyses, we do not distinguish between women who live in Ireland and Northern Ireland. Irish Customs officials confiscate incoming medications and women in Ireland must have their medications shipped to a Northern Irish address. Indeed, in some cases, it is not possible to distinguish between women living in Ireland and Northern Ireland, since some are already aware of the customs situation and report their country of origin as Northern Ireland. The border between the two countries is, at present, barely discernible and fully open to travel. Moreover, as described above, the situation women face in terms of accessing TOP in the two countries is very similar.

We then retrieved follow-up information for women to whom medications for TOP were shipped between 1st January 2010 and 31st December 2012. The number of women to whom medications are shipped is inevitably fewer than the number filling out an online consultation because some change their minds, experience a spontaneous miscarriage, decide travel to obtain TOP abroad, or decide to continue their pregnancy. The date range

2010-2012 was chosen for two reasons. First, the consultation and evaluation forms were developed over time and changes were made to the follow-up questions after the end of 2012. Between January 2010 and December 2012, however, the data collected remained constant. Second women accessing the service during this time period represent the entire population of women obtaining medical TOP online during those three years. In later years, alternative services began.

The consultation form asked women to share information about: age; weeks gestation at the time of request; any worries regarding feelings about the decision to terminate pregnancy, and for 2013-2015 only: parity; circumstances of pregnancy; and reasons for seeking TOP. We categorized age as “Under 20 years”, “20-24 years” and into 5-year increments thereafter, with a final group of “45 years and over”. For gestational age and worries regarding feelings, women selected from a list of options (displayed in Table 1). Women who expressed any worries were directed to appropriate sources of information and could choose to continue their consultation later. For circumstances of pregnancy and decision to terminate pregnancy, women could select one or more options from a list and/or write a free text response. Responses were integrated and women could choose as many responses as they desired (displayed in Table 1). The consultation form also included medical history questions, which were not analyzed in this study. Women could decline to answer any question that did not determine medical eligibility.

The evaluation form and email follow-up asked women to share: feelings regarding at-home medical TOP as an option; prior knowledge of medical TOP; difficulty affording the 70 Euro donation; adequate emotional support—defined as the ability to talk to family and friends and ask them for help; recommendation of at-home medical TOP to others in a similar situation; overall experience of at-home medical TOP—defined as whether or not at-home medical TOP was the right personal choice; and feelings after TOP was completed. For each variable, women could select one or more options from a list and/or write a free text response. Responses were integrated and women could choose as many responses as they desired (displayed in Table 2). Women could decline to answer any question. Women were also invited to share further long-format comments on their experiences with their pregnancy, seeking TOP, and at-home medical TOP using online telemedicine. The evaluation form also contained questions assessing resolution of pregnancy and presence of any medical complications, which were not examined in this study.

We examined numbers of women requesting TOP in each year between 2010 and 2015. For all six years combined, we examined the age distribution and the prevalence of each of the characteristics listed above. For women with available follow-up and who completed at-home TOP between 2010 and 2012, we examined each of the experiences listed above. Among the medical community, an important concern about at-home medical TOP is that women may lack sufficient help and support outside the clinical setting.[16] We hypothesized that women with the fewest economic resources would be more likely to lack adequate emotional and social support from family and friends, controlling for other characteristics such as age and weeks gestation. We tested this hypothesis using binary logistic regression. Finally, we conducted a content analysis of the long-format free text comments women provided about their pregnancy and their experiences with TOP. We coded the comments

according to an iteratively developed coding guide and manually collated the coded comments, resolving differing opinions through team discussion. The lead author then conducted content and thematic analysis of the collated comments according to the principles of grounded theory.[17]

Findings were considered statistically significant at an alpha level of 0.05. All data analysis was completed using Stata version 13.1 (StataCorp. 2013. College Station, Texas). De-identified data were provided to us by WoW. Women consented to the fully anonymized use of their data for research purposes at the time of submitting their consultation form. The Princeton University Institutional Review Board exempted the study from full review.

Results

The number of women living in Ireland and Northern Ireland seeking medical TOP through WoW has increased steadily over time. In 2010, 548 women performed an online consultation with WoW. By 2015, this number had more than doubled, to 1,438. Overall, between January 2010 and December 2015, 5,650 women contacted WoW to request medical TOP through the online consultation form. Among the 1,642 women to whom mifepristone and misoprostol were shipped between 2010 and 2012, follow-up data were obtained for 1,181 representing 72% follow-up. Of those with available follow-up data, 1,023 (87%) completed TOP. A sensitivity analysis of the characteristics drawn from the consultation form for women who did not complete follow-up indicated no meaningful differences compared to those of women for whom follow-up was complete.

Table 1 shows the characteristics of women who made an online request between 2010 and 2015. Women from all reproductive age groups are represented. Half were aged between 25 and 34 years and the majority (85%) were aged between 20 and 30 years. The mean age of a woman making a request was 30 years. The majority (63%) were mothers. Seventy-nine percent reported a gestational age of fewer than 7 weeks at the time of making their request, with the remaining 21% reporting between 7 and 9 weeks gestation. Slightly over half (54%) had experienced a contraceptive failure, 44% had not being using a method at the time of the pregnancy, and 2% had become pregnant as a result of rape. The most common reason for choosing to terminate pregnancy (reported by 62% of women) was not being able to cope with a child at this point in their lives. 44% reported having no money to provide for a child, and 23% felt their family was already complete. Thirty percent felt they were too young to have a child and/or wanted to finish their education. Virtually all women felt confident in their decision to end their pregnancies and had no worries about their feelings regarding TOP.

Table 2 shows the experiences of women completing medical TOP between 2010 and 2012. The majority (94%) felt grateful for the option of at-home medical TOP. Fewer than 1% said the option was not acceptable to them, yet proceeded with the termination anyway. Over half (57%) had prior knowledge of medical TOP before accessing the service. Thirty-five percent of women found it difficult to find the money to make a donation to support the service and almost one quarter (24%) reported a lack of adequate emotional support from friends and family. Overall, 97% felt that at-home medical TOP was the right choice for them and 98%

said that they would recommend the option to another woman in a similar situation. The most common feelings reported by women following their TOP were relief (70%), followed by satisfaction (36%). Almost half (49%) of women reported feeling happy and/or pleased. Smaller proportions reported feeling sad (12%) or guilty (17%). Very few women (3%) reported feeling disappointed. One fifth (20%) of women reported feeling confident and/or empowered.

Table 3 shows the factors associated with reporting lacking of emotional support from friends and family. Women who had difficulty affording a donation to the service had twice the risk of lacking emotional support (OR=2.0, $p<0.001$). We also observed a non-significant trend towards lack of emotional support for women who felt that the option of at-home medical TOP was acceptable rather than positive (OR=1.7, $p=0.09$). Age, weeks gestation, feelings about the option of medical TOP, and year showed no significant association with emotional support.

Four key themes emerged from the short descriptions women offered of their experiences with: 1) facing a pregnancy they either did not want or did not feel they could continue; and 2) at-home medical TOP through online telemedicine. For each theme, Appendix S1 provides illustrative examples.

First, women characterized the ability to choose at-home medical TOP as an essential service in the context of their personal circumstances. While each women's own context was unique, together they represented a wide and diverse range of circumstances, including: married mothers who felt their families were complete; single mothers working hard to make ends meet; migrant workers starting new lives; young women with dreams of completing their education; and survivors of rape and sexual violence. Some had always been pro-choice, while others were previously anti-abortion. All of these types of women expressed their relief at having the option of online telemedicine to end their pregnancies and the positive consequences they experienced. As one woman stated: “You gave me another chance to continue my personal battle as a single mother to create a good quality of life for my child, working hard in 3 jobs to make ends meet and create opportunities and potential for her future.”

Second, the experiences of women in Ireland and Northern Ireland with few economic and social resources suggest a grave inequity in their ability to access safe TOP. Women noted their inability to afford travel abroad, to take time away from children and work, to arrange travel without their families’ knowledge, or to travel at all due to migrant status. For some women the need travel would have caused long delays in accessing care, and for others, it would have rendered care completely impossible. The option of online telemedicine goes at least part of the way towards resolving this disparity in reproductive health and rights. As one women explained: “There is no way I could have afforded to travel to England, pay for the procedure, stay in a hotel, and have someone there to support me. Thanks to this service, was able to have a safe abortion in an environment where I felt comfortable and with my partner there to support me. Thank you for enabling women to have control over their own bodies.”

Third, the consequences of not having access to safe, legal TOP in Ireland and Northern Ireland can be severe. Women spoke of the stigma attached to pregnancy in some social circumstances, the stigma surrounding TOP, and the psychological suffering caused by having no option but to continue a pregnancy they did not want or feel they could continue. For some women, who described their only escape as either to turn to an unsafe method of termination or to commit suicide, the option of online telemedicine TOP was literally lifesaving. One woman represented the situation of many others when she said: “I can't thank you enough you have saved my life. I would have had to resort to desperate measures. You will never understand how grateful I am.”

Finally, women expressed anger and disappointment about their inability to access safe, legal TOP in their own countries. Some expressed their frustration as being treated as second-class citizens: “Abortion is a huge decision for some woman to make. It's shameful that we are met with brick walls and judgment in our own country.” Others pointed out that not even healthcare providers were free to advise women of their options, even when the woman's health and wellbeing were at serious risk.

Discussion

Main Findings

In Ireland and Northern Ireland, where safe TOP is not legally available through the formal healthcare setting, a diverse range of women access at-home medical TOP through online telemedicine. For majority of women, their experience is overwhelmingly positive, especially in light of their alternatives. Many faced a pregnancy they did not want or did not feel they could continue would otherwise have been forced to remain pregnant at severe cost to their psychological wellbeing. While online telemedicine TOP provides an important option for women who lack the economic resources to travel abroad, women with the fewest financial resources are still more likely to lack social and emotional support during and after at-home TOP.

Strengths and Limitations

The main strength of this study was our ability to undertake a novel analysis of the characteristics and experiences of a population of women about which no information has previously been available. While demand for TOP in Ireland and Northern Ireland is evident from the numbers of women traveling abroad for the procedure (between 2010 and 2012, 15,546 women traveled to England and Wales to access abortion)[8,10], the growing segment of women accessing telemedicine services provides evidence of an unmet need among those with the fewest resources.

The main limitation was that we were limited to assessing only the variables included in the online consultation and evaluation forms. Lack of information on characteristics such as education, race/ethnicity, and family/partner attitudes towards TOP may confound our examination of the factors associated with lack of social and emotional support. For example, the association we observed between having few financial resources and reporting a lack of support could be explained by a higher likelihood of experiencing stigma in

communities with lower socioeconomic status or by a reverse association, where lack of ability to confide in family and friends is associated with having fewer financial resources due to the inability to borrow money for the donation. Additionally, our study population is comprised of a group of women whose priorities were, understandably, not focused on completing a follow-up questionnaire. Out of respect to women's privacy and wellbeing, WoW does not intensively remind women to provide follow-up information. Some of the consultation and evaluation forms therefore contained some missing data, where women may have preferred not to respond, may have missed the question, or may not have volunteered this information via email. However, our follow-up rate is comparable to or, in some cases better than, studies of TOP services within the formal healthcare setting.[18] Since we rely on self-reported data, we cannot verify that women provided accurate information on their age, parity, or weeks gestation. However, for the most part, subjective experiences are exactly what we aimed to assess. An additional limitation is that those who elected to provide detailed information about their experiences with pregnancy and abortion were a self-selected group and some groups of women may be more likely than others to provide information. Our analysis was limited to these women's responses to an open-ended online question, which did not allow for the same depth or detail as an in-depth interview or focus group scenario.

Interpretation

Our study is the first to examine the characteristics and experiences of women living in Ireland and Northern Ireland who sought and completed at-home medical TOP through online telemedicine. Previous studies of telemedicine in other settings where safe TOP is unavailable have examined a more limited set of variables. A small study of 307 women in Brazil showed that all women found the option of medical TOP acceptable and that half had prior knowledge of medical TOP.[15] In a study of 484 women in 33 different countries, the mean age of women requesting TOP was slightly younger than we observed in Ireland and Northern Ireland (27 years), a similar proportion of women were fewer than 7 weeks pregnant (80%), a higher proportion (47%) had no children, and a similar proportion had become pregnant as a result of rape (2%).[14] In settings where safe TOP is legally available, telemedicine services have also been rated highly acceptable by both patients and clinicians.[19] A recent review of the acceptability of self-managed TOP in both legal and legally-restricted contexts (not including Ireland or Northern Ireland) emphasizes the role of local attitudes surrounding termination, the importance of access to support and information, and the generally strong sense of satisfaction among women across settings.[20]

Women seeking at-home medical TOP are a sub-population of all of the women in Ireland and Northern Ireland requiring access to safe TOP services: some women travel to access TOP abroad, some actively seek TOP care but are unable to obtain it, while others may not feel able to seek TOP at all. Further research is needed to integrate the experiences of women obtaining medical TOP at-home with those who travel abroad to access TOP and to examine differences and similarities between the two groups. Research is also needed to further explore the experiences of those who are unable to obtain care by either route and are forced to continue their pregnancies or resort to an unsafe method.

Abortion laws both in Ireland and in Northern Ireland have been the subjects of recent intense political and public debate. In Northern Ireland, challenges to the existing abortion law are predicted to reach the Supreme Court of the United Kingdom[7]. In Ireland, doctors have called for a referendum[21] and the Irish parliament will soon debate a measure to repeal the 8th amendment to the constitution, which renders TOP illegal in nearly all circumstances.

Our findings strongly suggest that by far the most negative component of women's experiences with at-home medical TOP is the need to maintain secrecy and silence because of the social stigma and a fear of prosecution engendered by its illegal status. While obtaining mifepristone and misoprostol is not illegal under Irish or Northern Irish laws, using the medications to end a pregnancy outside the extremely limited scope of the law is a criminal offense. In Northern Ireland, two women have recently been charged with unlawfully procuring TOP, one a mother obtaining medications for her daughter and the other a 21-year old woman obtaining medications for self-use.[7] Women in Northern Ireland protested these charges by coming forward to reveal their own use of mifepristone and misoprostol and demanding to be arrested.[22]

A woman seeking follow-up care after an at-home medical TOP may also risk being reported to the police by a healthcare professional who believes she has broken the law. A recent update to the responsibilities of healthcare providers in Northern Ireland clarifies that medical staff need not ask a woman whether she attempted TOP when providing treatment.[23] This clarification frees providers from a potential legal obligation, but does not prevent them from reporting women should they choose to do so. In Ireland, the uncertain interpretation of abortion laws has had fatal consequences, including the death of Savita Halappanava from septicemia because clinicians were unable to decide whether TOP could be carried out without themselves risking criminal charges. Such incidents prompted the human rights committee of the United Nations to call on Ireland to enact legal reform.[24] The few studies that examine clinician attitudes indicate that a majority of obstetricians, gynecologists, and general practitioners surveyed in Northern Ireland, and a majority of general practitioners surveyed in Ireland support legal reform.[25-28]

Conclusion

This study provides evidence of the unmet need for TOP services in Ireland and Northern Ireland, particularly among a population of women who lack the financial means to travel abroad to access services. While these women's experiences with at-home medical TOP are positive—especially in light of the harm to their health and wellbeing that would have resulted had this option been unavailable to them—they nonetheless risk criminal prosecution. These insights contribute a new dimension to the policy debate surrounding abortion laws in Ireland and Northern Ireland, highlighting the public health advantages of providing safe, legal TOP services, and calling attention to a profound inequity in reproductive health access.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

Characteristics of women living in Ireland and Northern Ireland requesting at-home medical TOP through Women on Web, 2010-2015 (n=5,650)

Reported Characteristic	Frequency(%)
Age	
Under 20	4.6
20-24	16.6
25-29	24.1
30-34	25.8
35-39	18.1
40-44	8.2
45 and over	2.6
Parity[a]	
0	36.7
1	22.8
2	22.4
3	12.3
4 or more	5.8
Weeks gestation	
Fewer than 7 weeks	79.0
Between 7 and 9 weeks	21.0
Circumstances of pregnancy[b]	
Did not use contraception	44.0
Contraception used incorrectly or did not work	54.3
Rape	1.7
Reasons decided to terminate pregnancy[c]	
I just cannot cope with a child at this point in my life	62.1
I have no money to raise a child	43.5
My family is complete	23.0
I feel I am too young to have a child	15.3
I want to finish school	14.8
I feel I am too old to have a child	4.6
I have health problems	1.5
Feelings about decision to have a TOP	
I can cope with my feelings regarding my decision	99.8
I have some worries about my feelings	0.2

[a] Information available for 2013-2015 only, n=3,500. 95 women declined to respond.

[b] Information available for 2013-2015 only, n=3,500. 39 women declined to respond.

[c] Information available for 2013-2015 only, n=3,500. 41 women to declined to respond. Percentages do not sum to 100.0 because women could chose more than one reason.

Table 2

Experiences of women living in Ireland and Northern Ireland completing at-home medical TOP through Women on Web, 2010-2012 (n=1,023)

Reported Experience	Frequency (%)
Feelings about the option of obtaining medical TOP online[a]	
Grateful	94.2
Acceptable	5.6
Not acceptable for me	0.2
Prior knowledge of medical TOP[b]	
Yes	57.4
No	42.5
Difficulty affording the donation[c]	
Yes	34.6
No	65.4
Emotional support from family and friends [d]	
Could not talk to family and friends or ask them for help	24.3
Could talk to family and friends and ask them for help	75.7
Overall experience of at-home medical TOP[e]	
At-home medical TOP was the right choice for me	97.2
At-home medical TOP was not the right choice for me	2.8
Recommendation to others with an unwanted pregnancy [f]	
Would recommend at-home medical TOP	98.2
Would not recommend at-home medical TOP	1.8
Feelings after completing at-home medical TOP[g]	
Relieved	70.0
Satisfied	35.8
Happy	26.8
Pleased	22.1
Guilty	17.4
Sad	11.6
Confident	10.0
Empowered	9.6
Feelings of loss	7.9

Reported Experience	Frequency (%)
Low	6.6
Disappointed	2.6

[a] 92 women declined to provide this information.

[b] 153 women declined to provide this information.

[c] 84 women declined to provide this information.

[d] 228 women declined to provide this information.

[e] 77 women declined to provide this information.

[f] 88 women declined to provide this information.

[g] 129 women declined to provide this information. Percentages do not sum to 100 because women could choose more than one response.

Table 3

Factors predicting lack of emotional support among women living in Ireland and Northern Ireland completing at-home medical TOP (n=760)

Characteristic	Odds Ratio	P-value
Age		
20-24	0.66	0.28
25-29	1.01	0.95
30-34	ref	ref
35-39	0.68	0.11
40-44	0.80	0.45
45 and over	0.42	0.10
Weeks gestation		
Less than 7 weeks	ref	ref
Between 7 and 9 weeks	0.81	0.32
Difficulty affording the donation		
No	ref	
Yes	2.00	0.00
Feelings about option of obtaining medical TOP online		
Grateful	ref	ref
Acceptable	1.74	0.09
Prior knowledge of medical TOP		
Yes	ref	ref
No	1.17	0.37
Year		
2010	ref	ref
2011	0.98	0.92
2012	0.87	0.55

The two women who reported that at-home medical TOP was an unacceptable option and the four women who were under 20 are omitted as they are too few to allow meaningful analysis as a separate group.