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HOME USE OF BOTH PILLS FOR EARLY MEDICAL ABORTION UP TO 10 WEEKS GESTATION

Do you consider that the temporary measure has had an impact on the provision of abortion services for women and girls accessing these services with particular regard to safety?

a) Yes, it has had a positive impact

Research shows that home use of mifepristone and misoprostol are a safe and highly acceptable form of abortion provision for women (Endler et al, 2019). Abortion by telemedicine is as successful and has the same small incidence of complications as in-clinic care (Aiken et al, 2021).

Do you consider that the temporary measure has had an impact on the provision of abortion services for women and girls accessing these services with particular regard to accessibility?

a) Yes, it has had a positive impact

Research shows that 80% of people expressed a preference for remote abortion if they were to have another abortion in future (Aiken et al, 2021).

Remote care for the termination of pregnancies enabled by home use of medication is necessary to improve access to abortion care (Romanis, et al, 2020).

There is clear evidence that without home use women who need abortions and cannot get to a clinic will attempt to access medication illegally online (Aiken et al, 2018). Women who attempted to unlawfully accessed the medication this way stated they were unable to get to a clinic for a whole variety of reasons. Among all reasons: 49% were due to access barriers, including long waiting times, distance to clinic, work or childcare commitments, lack of eligibility for free NHS services, and prior negative experiences of abortion care; 30% were due to privacy concerns, including lack of confidentiality of services, perceived or experienced stigma, and preferring the privacy and comfort of using pills at home; and 18% were due to controlling circumstances, including partner violence and partner/family control. Therefore, home use is needed to support these women to access safe, compassionate, and respectful abortion care.

Do you consider that the temporary measure has had an impact on the provision of abortion services for women and girls accessing these services with particular regard to privacy and confidentiality of access?

a) Yes, it has had a positive impact

Research shows us that some women feel they cannot access abortion care provided in clinics due to privacy concerns, specifically they are worried they will be seen going to an abortion clinic (Aiken et al, 2021). This is particularly the case in small and/or tight-knit communities where women may be very worried about approaching their GP and/or entering a clinic. On this basis, continued provision of home use of both pills is needed for equality and diversity. Think, for example, of women who live within devout and strict religious communities and so do not feel they can risk being seen to be attempting to access an abortion. These women are driven to access illegal medication due to a requirement that they obtain the medication from a clinic.

Do you consider that the temporary measure has had an impact on the provision of abortion services for those providing services? This might include greater workforce flexibility, efficiency of service delivery, value for money etc.

a) Yes, it has had a positive impact

Department for Health and Social Care (2021) data shows us that home use has resulted in more abortions taking place at an earlier stage of gestation, compared to last year. Earlier provision of abortion means less likelihood of complications, and so reduces the need for further service provision. Research shows us that home use of misoprostol has a positive impact of reducing waiting times and ensuring the effective organisation of services. (Lohr et al, 2020).

It must be remembered, however, that some women will want an in-person appointment in order to access the face-to-face support currently provided by British Pregnancy Advisory Service (BPAS) and MSI Reproductive Choices. Home use must not replace in-person appointments. Women must be given a choice as to the nature of the appointment that works best for them. Funding for abortion providers should not be cut, and clinics should not be closed. Closing clinics would mean women have to travel further for in-person appointments; this would limit the availability of services and support for women, particularly those with increased vulnerabilities and with complex care needs.

What information do you consider should be given to women around the risks of accessing pills under the temporary measure if their pregnancy may potentially be over 10 weeks gestation?

There is a lot of evidence that indicates that people can reliably date their pregnancies using their last menstrual period. Research shows us that of all abortions involving both pills being taken at home only 0.04% occurred in cases whereby the woman was more than 10 weeks pregnant (Aiken et al, 2021).

There is also evidence that medication abortion is safe past the 10 week gestational limit that is recommended in the UK (see World Health Organization abortion care guidance, 2012, page 45). The use of the medications later in pregnancy only slightly increase the risk of complications. It may be more painful for women and the products of the pregnancy that she passes may be larger than she is expecting. However, service providers such as BPAS

have 24/7 support lines, so women are supported with any concerns or worries they have with their post-abortion care.

I have recently produced an article for *The Conversation* (Milne 2021) in which I argue that we should see abortions that take place later in pregnancy (notably after 24 weeks) as distinct from home abortions. As I argue, whether home use continues or not, a very small number of women will continue to illegally access medication to end a pregnancy of a viable foetus. Abortion medication is relatively easy to obtain illegally via the internet. In 2015 and 2016, 645 abortion pills were seized en-route to addresses across Britain. It is likely that far more made it to their destination. Home use will reduce some women's desperate need for this illegal trade.

Women who are in desperate circumstances are distinct from the vast majority of abortion cases that occur. And those who do find themselves in the position of needing to end a late-term pregnancy are incredibly vulnerable. My research shows that women in this situation experience what is known as a "crisis" pregnancy. An unwanted pregnancy is not necessarily a crisis pregnancy, if a woman has access to safe and legal abortion services.

The crisis arises because of difficult life circumstances these women are enduring, such as living in violent and abusive relationships or living poverty with limited social support.

Considering the stage of the pregnancy, the dire context that surrounds them and the steps women take to end them, these crisis cases need to be seen as distinct from "regular" abortions, which generally occur very early in the pregnancy – with just 0.1% taking place at or after 24 weeks, according to national data from 2019. Most of these post-24 weeks terminations will be of wanted pregnancies following a diagnosis of foetal abnormalities.

My research has shown that crisis pregnancy cases are, in fact, more akin to newborn infanticide. This is when a newborn baby is killed with the child's mother being the most likely suspect. In these cases the woman often acts out of fear, shame and a belief that their pregnancy cannot exist. There needs to be a debate about whether it is right to criminalise these women, considering their levels of vulnerability. I do not believe it is.

Whether or not home use for early medical abortion is legally permitted, women in crisis will find means to end their pregnancy – they have in the past and they will again.

Governments do not ban alcohol because some people drink and drive. Why should they ban home use abortion pills because a very small number of women will knowingly be over 10 weeks pregnant when they request the medication?

These vulnerable women need support. And they should not be used to prevent all women from easily accessing safe and compassionate abortion care at home.

Outside of the pandemic do you consider there are benefits or disadvantages in relation to safeguarding and women's safety in requiring them to make at least one visit to a service to be assessed by a clinician?

a) Yes, benefits

The key point here is to give women choice about the nature of the abortion they want!

Home use of both abortion medications does not necessarily mean that consultation will be remote. This change in the law would allow completely remote abortion care including consultation by phone or videolink. However, in some instances it would also mean that women who prefer to be seen in a clinic. Or, if service providers consider her to vulnerable then they may request that she attend a clinic appointment. Following a clinic appointment, both pills could still be administered in a place where the woman feels more comfortable.

As noted above, home use of both pills is safe. Vulnerable women, notably those living in abusive and violent relationships may struggle to get to a clinic. So, home use is a far safer option for them, for their overall health as well as abortion care (Aiken et al, 2018).

To what extent do you consider making permanent home use of both pills could have a differential impact on groups of people or communities? For example, what is the impact of being able to take both pills for EMA at home on people with a disability or on people from different ethnic or religious backgrounds?

Increasing access to abortion medication through the private means of a telephone or video consultation would have substantial benefit for all women who struggle to get to a clinic for any reason. This includes women who will experience shame and stigma if it becomes known that they have attempted to procure an abortion; women who are disabled and so struggle to access a clinic due to their disability; women who are living within controlling and abusive environments, such as intimate partner violence and abuse, or familial abuse (Romanis, et al, 2020; Aiken et al, 2018).

To what extent do you consider that making permanent home use of both pills for EMA would increase or reduce the difference in access to abortion for women from more deprived backgrounds or between geographical areas with different levels of disadvantage?

As abortion clinics are mostly in larger towns and cities, women in rural areas often struggle to attend an in-person clinic appointment. Thus, pre-home use provision disadvantages women who live outside of towns and cities (Romanis, et al, 2020; Aiken et al, 2018). This disadvantage will be greater for women who struggle to obtain childcare, those required to take time from work (which may be unpaid), and women who do not have access to private transport. Thus, a requirement for in-clinic appointments is discriminatory for women from low-income households.

Have you any other comments you wish to make about whether to make home use of both pills for EMA a permanent measure?

The construction and definition of ‘home’ in the current home use provision is discriminatory against some women as it restricts access. There are a number of reasons why a woman would be safer if the medication is sent to a location other than her home (such as a friend’s house or her place of employment), for example: women who will experience shame and stigma if it becomes known by their family that they have attempted to procure an abortion,

and women who are living within controlling and abusive environments, such as intimate partner violence and abuse, or familial abuse.

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