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The Women's Health Strategy must be women-centred. In relation to reproductive rights this means:

- Women-centred maternity care at all stages of pregnancy, labour, and delivery.
- Decriminalisation of abortion so that it can be regulated as medical care, not a criminal justice issue.
- Continued access to home use of both pills for early medical abortions.
- Continued access to abortion care in clinic settings, with no reduction in funding for service providers.

WOMEN-CENTRED MATERNITY CARE

Care for women during pregnancy, labour, and delivery must be women-centred, rather than foetus-centred. There is a worrying trend towards the foetus-first mentality in maternity care and beyond (Milne, 2020). Of note, there are substantial concerns over the proposals by NICE for amendment the quality standard for Fetal Alcohol Spectrum Disorder (FASD) to record women's consumption of alcohol and to transfer that information to the child's records after birth. This proposed change is likely to alienate women. It will increasingly make their healthcare during pregnancy for the benefit of the foetus, rather than for their benefit (see my response to the NICE consultation here). The NICE proposals are but one example. It must be remembered that when women become pregnant, they do not lose their autonomy or the right to control their bodies. They continue to be the patient, and care needs to focus on them: the word midwife means "with woman", not "with foetus". However, reports by charities such as Birthrights indicates that this is not women's experiences of care.

DECRIMINALISATION OF ABORTION

Access to safe and legal abortion is essential for women's health. One in three women will have at least one abortion in their life time. The criminal law framework around abortion is detrimental to women's health. Abortion is a medical issue: a concern for women, and women alone. In 2021 women should not face criminal sanctions and up to life imprisonment for deciding to end a pregnancy. The current legal framework for abortion provision in England, Scotland, and Wales hinders the care that can be given to women by medical professionals, thus harming women's health. As my research indicates (Milne, 2021), those women who have faced criminal sanctions for ending a pregnancy are incredibly vulnerable. They need support and care, not criminalisation. Sections 58 and 59 of the Offences Against the Person Act 1861 and the Infant Life (Preservation) Act 1929 must be repealed. As

Sheldon and Wellings (2020) outline, decriminalisation does not mean deregulation, but it would mean significant improvements for women's health.

HOME USE OF ABORTION MEDICATION

It is essential that women continue to be able to access both abortion medications for use at home. Home use of both pills is safe. 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). Research shows that 80% of women expressed a preference for remote abortion if they were to have another abortion in the future (Aiken et al, 2021). There is clear evidence that without home use women who need abortions and cannot get to a clinic will attempt to illegally access medication online (Aiken et al, 2018), so facing life imprisonment.

Vulnerable women, notably those living in abusive and violent relationships may struggle to attend a clinic. So, home use is a far safer option for them: for their overall health as well as their abortion care (Aiken et al, 2018). Increasing access to abortion medication through 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).

ABORTION CARE IN CLINICS

It must be remembered that some women who request abortions 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 cannot be cut, and clinics should not be closed. Closing clinics would mean women are required 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.

For many women, accessing abortion care will be one of the few opportunities to discuss their reproductive and sexual health. Many women will want to do this in-person. Such provision of care must continue, and so resources allocated to charities that provide this care must not be cut.

ABOUT DR EMMA MILNE

Dr Emma Milne is Assistant Professor in Criminal Law and Criminal Justice at Durham University. Her PhD in Sociology from the University of Essex was funded by the Arts and Humanities Research Council. Emma's research is interdisciplinary, focusing on criminal law and criminal justice responses to newborn child killing and foetal harm. The wider context of Emma's work is social controls and regulations of all women, notably in relation to pregnancy, sex and reproduction. Emma's monograph *Criminal Justice Responses to Maternal Filicide: Judging the Failed Mother* is due for publication in autumn 2021 (Emerald Publishing Limited). She co-authored *Sex and Crime* (SAGE, 2020), and co-edited *Women and the Criminal Justice System: Failing Victims and Offenders?* (Palgrave, 2018).

References

Aiken, ARA, Lohr, PA, Lord, J, Ghosh, N, Starling, J (2021) Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study. *BJOG*. Available at: https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.16668.

Aiken ARA, Guthrie KA, Schellekens M, Trussell J, Gomperts R (2018) Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain. *Contraception*. 97(2):177-183. Available at: https://www.contraceptionjournal.org/article/S0010-7824(17)30435-3/fulltext.

Milne E (2021) *Criminal Justice Responses to Maternal Filicide: Judging the Failed Mother*. Bingley: Emerald.

Milne E (2020) Putting the Fetus First — Legal Regulation, Motherhood, and Pregnancy. *Michigan Journal of Gender & Law.* 27(1): 149-211.

Romanis EC, Parsons JA, Hodson N (2020) COVID-19 and reproductive justice in Great Britain and the United States: ensuring access to abortion care during a global pandemic. *Journal of Law and the Biosciences*. 7(1). Available at: https://academic.oup.com/jlb/article/7/1/lsaa027/5838025.

Sheldon S and Wellings K (eds.) (2020) *Decriminalising Abortion in the UK: What Would It Mean?* Bristol: Policy Press.