Impact of home use of both pills for abortions up to 10 weeks gestation

Consultation Questions

Deadline: 26th February 2021

Suggested answers are offered below but we stress you use your own individual words because each response submitted is made by an individual on their own behalf. Responses found to be written in the same words may be ignored by the government.

For background information, we recommend that you read VfJUK's Report, but as a basic minimum, you should read the Executive Summary of our Report, and also Background to the Consultation.

For VfJUK's Executive Summary of the key issues from our Report, read here.

For VfJUK's Report, read here.

For the Department of Health and Social Care's page on the Consultation, read here.

For the online questions, read here.

For supporting sources cited in the responses below, please go to our report.

Voice for Justice UK is unashamedly pro-life in its values. Our suggested responses to Consultation questions is not to be treated as endorsing abortions, otherwise performed in hospital or clinic-based settings.

Our responses take careful account of the myriad safety risks and harms women can face, in the absence of necessary physical tests to confirm gestation and relevant health issues. On this basis, we therefore reject telemedicine consultations and the subsequent at-home abortions as being dangerous for women. In our Report, we cite a variety of trusted medical authorities, including all sources, in support of our material.

Questions and Responses

Question 1: 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

b) Yes, it has had a negative impact

c) It has not had an impact

d) I don't know

Response: We suggest you choose b, and provide reasons in the box provided. Please use your own words. You may choose from the list below. You don't have to explain details but indicate general areas of concern. You can, however, go into more details if you wish.

Women undergoing early medical abortion (EMA), who are not seen in person and examined by way of ultrasound scan or other tests, face a variety of health risks:

- **Incomplete abortion** Without medical supervision, women may, for whatever reason, not take the two pills (mifepristone and misoprostol) at the prescribed time-intervals of 24 to 48 hours; failure to do so may result in an incomplete abortion. If these drugs are taken at a later gestation, this risks heavier bleeding.

- **Inaccurate reporting** At-home EMAs does away with the routine ultrasound scan that previously confirmed the gestational age of the foetus. Reliance on a woman's honest recall of her last menstrual period may not be accurate. If the age of the foetus exceeds the 9 week 6 day limit, at-home abortion is illegal but also poses serious health risks. A later gestation can mean the need for surgical intervention.

- **Infection** In up to 10% of cases, there are complications involving infection.

- **No antibiotics** Abortions performed without antibiotics (these are used before surgery or a dental procedure) risks the later development of Pelvic Inflammatory Disease, putting women at greater risk of subsequent infertility.

- **No screening for STIs** The Royal College of Obstetricians and Gynaecologists recommends screening for chlamydia and other STIs for women having abortions; this cannot be done unless there's a face to face appointment.

- **Haemorrhage risk** There are risks of haemorrhage.

- **Access to emergency medical care** According to the Electronic Medicines Compendium (EMC), if an emergency develops, the woman must not only have access to appropriate medical care, the procedure should only be performed where she "has access to medical facilities equipped to provide surgical treatment for incomplete abortion, or emergency blood transfusion or resuscitation during the period from the first visit until discharged by the administering qualified medical professional." Women who self-administer abortion drugs at home are not in immediate proximity to the medical care that a hospital or clinical setting provides.

- **Risks of failed abortion** For risks of failure of the abortion, the EMC states: "The non-negligible risk of failure, which occurs in 4.5 to 7.8% of the cases, makes the follow-up visit mandatory in order to check that abortion is complete." In cases of failed abortion, the EMC advises women must be informed about the occurrence of prolonged vaginal bleeding. In some cases, heavy bleeding may require surgical evacuation of the uterus. "Bleeding is not in any way a proof of termination of pregnancy as it occurs also in most cases of failure." (EMC)

- **Required follow-up examinations** The EMC advises that follow-up examinations *must* take place within a 14-21 day period after taking mifepristone. This allows for checks to be done by either ultrasound scan, clinical examination or hCG blood tests to confirm the completion of the abortion and that vaginal bleeding has stopped or lessened.

- **Pills must not be prescribed without confirmed pregnancy** Of the two abortion drugs women will self-administer at home, the EMC warns: "This product SHOULD NEVER be prescribed" in situations that include a "pregnancy not confirmed by gynaecological examination, ultrasound scan or biological tests."

- **Dangers of Class B drug** In treatment packs sent to women seeking abortion, codeine phosphate is included for pain management. This is a Class B drug, addictive in nature, and not given over the pharmacy counter without a prescription. Professional guidance from NICE advises ibuprofen for heavy vaginal bleeding, or in other cases, paracetamol. Vulnerable women are at high risk of overdosing on these tablets.

- **Health minister's safety concerns** Days before the new 2020 rules on home abortions were brought in, the Health Minister rejected calls for legal changes on safety grounds: "The safety of women remains our priority, but it is vital that appropriate checks and balances remain in place regarding abortion services … there are long-established arrangements in place for doctors to certify and perform abortions, and they are there for good reason."

- **Hygiene standards** Residential settings cannot be expected to comply with the hygiene standards of clinics or hospitals: *Royal College of Nursing vs Department of Health and Social Security* (1981). In this case, it was stated that one of the purposes of the Abortion Act 1967, was to "ensure that the abortion is carried out with all proper skill and in hygienic conditions."

- **Who will take the pills?** The abortion pills may not be taken by the woman asking for them, and instead, may be consumed by a woman whose medical history or gestation places her at medical risk.

- **Transparency & disclosure of all risks** Every woman seeking an abortion must be told of any risks faced by the procedure, regardless of their likelihood. Generally, risks have to be disclosed to the patient in line with the 'Montgomery' principles: "whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it." Therefore, in not telling women the full risks, abortion providers are non-compliant and further endangering women's health.

- As international research shows, women can feel coerced into abortion decisions by abusive partners. **(You may wish to include it here, but this subject is better raised under Question 3)**

Question 2: 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

b) Yes, it has had a negative impact

c) It has not had an impact

d) I don't know

Response: We suggest you choose d.

You may want to add the fact that because women are not subjected to a routine medical assessment and safety checks trivialises the procedure, while also making it impossible to check on the identity of the intended recipient.

Question 3: 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

b) Yes, it has had a negative impact

c) It has not had an impact

d) I don't know

Response: We suggest you choose b. You can also elaborate with the following suggested points:

- **Freedom from coercion** Privacy and confidentiality implies that an abortion decision is completely free from possible partner intimidation, coercion or abuse. Research shows that intimate partner violence accounts as a strong risk factor in abortion around the world.

- **Missing signs of partner coercion from remote consultation** It isn't likely that abuse will be detected remotely, and it cannot be ensured that a woman is in a safe environment, free from the coercion or abuse of a partner. Only a face to

face consultation is likely to uncover domestic abuse or coercion issues that may be pushing a woman against her will into an abortion.

- **Health Minister's concerns** Shortly before the new at-home abortion rules came into effect in March 2020, the Health Minister said how it's an "essential safeguard that a woman attends a clinic, to ensure that she has an opportunity to be seen alone and to ensure that there are no issues." Summing up the common-sense concerns of many people, he concluded: "The bottom line is that, if there is an abusive relationship and no legal requirement for a doctor's involvement, it is far more likely that a vulnerable woman could be pressured into have an abortion by an abusive partner."

Question 4: 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

b) Yes, it has had a negative impact

c) It has not had an impact

d) I don't know

Response: We suggest you choose d.

Question 5: Have other NHS services been affected by the temporary measure?

a) Yes [please provide details of which services]

b) No

c) I don't know

Response: We suggest you choose a.

To support your answer, you can make the point that NHS resources will be stretched, as they already are, to provide ambulances and emergency care to treat infection, as well as problems arising from incomplete abortion. There is also the likelihood of some women taking the abortion pills beyond the legal limit of 10 weeks.

Question 6: 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?

Suggested items to include in your answer are:

- **Risks of mis-timing** Women must be told of all the possible medical harms, following from the self-administering of mifepristone and misoprostol, as laid out in the Electronic Medicines Compendium (*see: Response to Question 1*). Essentially, if the pills are taken by a woman whose gestation is over 10 weeks, the woman's health is placed at risk, and her abortion is likely to be incomplete, making a surgical intervention more likely.

- **Mental health risks** Regardless of the gestation, women should be given time to reflect on an abortion decision. Some may go on to regret their choice, while others suffer long-term mental health problems. The Report of the APA Task Force on Mental Health and Abortion (2008) is a through examination of the mental health risks which affect various groups of women. Therefore, information about all post-abortion mental health risks should not be played down, treated as negligible, nor silenced. Despite the lack of a consensus about the causal links between abortion and subsequent mental health risks, women should be told about all relevant risks.

- **Informed patient consent** As medical procedures involve patient consent, this implies full knowledge of the risks, with the possibility for a change of mind. As noted for Question 1 above, the risks have to be given to the patient in line with the 'Montgomery' principles (see Transparency & disclosure of all risks, p. 4).

- **Provide alternatives** It is not disputed that many women considering abortion are uncertain and not confident about their decision. Whatever the gestation, women should always be offered the possibility of adoption. It is unacceptable when abortion providers repeat the "women must be trusted" mantra, suggesting that whenever a woman presents for abortion, her decision should either not be questioned, or she shouldn't be informed about alternatives. In order to make her decision, she must be given *all* information and support, enabling her to make a fully informed choice. Abortionists like to call their

position "pro-choice", yet abortion decisions not based on all the available options plainly aren't based on an *informed choice*.

- **Give the facts** As part of a fully informed decision, women must be given uncontested biological facts about the development of the unborn baby; as, for example, when the heart starts to beat, measurable brain activity, and at what stage the baby feels pain.

Question 7: 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

b) Yes, disadvantages

c) No)

d) I don't know

Response: we suggest you choose a.

The medical benefits for a woman who makes at least one visit to a clinic include:

- **Confirming abortion is complete** If a clinic visit is made following the first pill, mifepristone, this means the termination can be confirmed; however, unless a visit is made after taking the second dose too, misoprostol, the abortion may not be complete (expulsion of the foetus) if, for example, the second dose wasn't taken at the prescribed interval.
- **Detecting ectopic pregnancies** Ectopic pregnancies don't always have symptoms, so should be diagnosed. Remote consultation can easily miss diagnosis. Various tests can provide confirmation: a pregnancy test using urine or blood; ultrasound scan; a laparoscopy.[i] Ectopic pregnancies are very serious and may be fatal, if untreated. About 2 in every 100 women have ectopic pregnancies.
- **Missing signs of partner coercion from remote consultation** It isn't impossible to detect abuse remotely, and to ensure a woman is in a safe environment, free from the coercion or abuse of a partner. Only a face to face consultation is likely to uncover domestic abuse or coercion issues that may be pushing a woman against her will into an abortion. *This was mentioned under question 3 and you may want to repeat the point here.*

Public sector equality duty

This question introduces equality issues, and the protected characteristics enshrined in the Equality Act 2010. You are asked to express views on the impact of making permanent the home use of both abortion pills for people with protected characteristics. You are also being asked to consider mitigation steps that could be taken against any adverse impact against the government's equality duties.

Of nine protected characteristics,[ii] relevant ones for these purposes are: religion or belief and pregnancy.

Question 8: To what extent do you consider making permanent home use of both pills could have a differential impact on groups of people or communities?

One example you are asked to consider: "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?"

Religion or belief

- The measure risks alienating religious groups where abortion is prohibited, enhancing the risk of possible radicalisation and extremism.

- It also increases the risk of sexual exploitation by grooming gangs, who will be able more easily to force young (underage) victims to have an abortion.

- Staff not normally asked to participate in the abortion process, could be expected to assist in the recording and administration of data relating to telemedicine abortions; packaging of pills; or distribution of treatment packs containing the pills. The staff affected could include: medical or other NHS staff, and those working in roles outsourced by the NHS.

  There is a conscientious objection clause in the Abortion Act 1967 but this only applies to hospital or clinic staff (medical practitioners, nurses) who might otherwise participate in abortion 'treatment'. Conscientious objectors refusing to work in these administrative, packaging and distributive roles would be without legal protection. They would require additional statutory protection, enabling them to exercise their right to conscientious objection.

- **Pregnancy** As a protected characteristic, a pregnant woman attracts legal protection from discrimination. It may be argued she is being treated unfavourably, and therefore discriminated against, compared to pregnant women with later gestations who are given complete at-clinic medical care and supervision.

Socioeconomic considerations

In addition to the protected characteristics, views are also being sought on the potential for making permanent home use of both pills for EMA, to "reduce or increase inequality in health outcomes experienced by different socioeconomic groups."

Question 9: **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?**

- **Disadvantaged** According to the 2019 Abortion statistics: "Women living in more deprived areas are more likely to have abortions than women living in less deprived areas."[iii] This means women who might otherwise want to keep their child may, for financial reasons and as result of this measure, be encouraged to choose abortion.

Whether to make home use of both pills for EMA a permanent measure

Question 10: **Should the temporary measure enabling home use of both pills for EMA [select one of the below]**

a) Become a permanent measure?

b) End immediately?

c) As set out in the current temporary approval, be time limited for 2 years or end when the temporary provisions of the Coronavirus Act 2020 expire, whichever is earlier?

d) Be extended for one year from the date on which the response to this consultation is published, to enable further data on home use of both pills for EMA and evidence on the temporary approval's impact on delivery of abortion services to be gathered?

e) Other [please provide details]?

Response: We suggest you choose b.

Question 11: Have you any other comments you wish to make about whether to make home use of both pills for EMA a permanent measure?

You may want to sum up the numerous medical risks faced by women:

- They are denied the essential opportunity for ultrasound scan, physical or blood tests. Without these, a woman is exposed to serious health risks and harms.

- Without access to immediate medical supervision and care while performing their own abortion at home, a woman is exposed to medical dangers.

- Home abortions should be terminated with immediate effect. This includes administration of either one or two pills.

References

[i] A form of keyhole surgery providing access to the inside of the abdomen.
[ii] For an overview of all the protected characteristics, see:
https://www.equalityhumanrights.com/en/equality-act/protected-characteristics.
[iii] *Abortion Statistics, England and Wales: 2019*, p. 16 (Department of Health and Social Care)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/891405/abortion-statistics-commentary-2019.pdf