RightToLife

Consultation guide

UK Government's consultation on home use of both pills for early medical abortion up to 10 weeks gestation

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Introduction

The UK Government has launched a consultation on whether to make permanent the current temporary arrangement allowing 'DIY' home abortions to take place in England.

The consultation closes at 11:59 pm on 26 February 2021.

Full details on the consultation are available here: https://www.gov.uk/government/consultations/home-use-of-both-pills-for-early-medical-abortion

How to respond

Online - via consultation hub

1. Visit https://www.gov.uk/government/consultations/home-use-of-both-pills-for-early-medical-abortion.
    - Under 'Ways to respond', click 'Respond Online'
    - Please note - you can save and return to your responses while the consultation is still open.
2. Complete the process
3. Submit

Post

1. Download our easy to fill in form here.
2. Return your completed form by post to:

    Abortion Consultation
    Ministerial Correspondence and Public Enquiries Unit
    Department of Health and Social Care
    39 Victoria Street
    London
    SW1H 0EU
    United Kingdom

Consultation response guide

For each question, we have provided a suggested answer and points that can be included in the optional comments section to support your answer.

Question 1

1. Question: 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?**

Yes it has had a positive impact	
Yes, it has had a negative impact	**x**
It has not had an impact	
I don't know	

Points that can be included in the optional comments section:

1. **Serious medical complications**
   Medical abortions at home have led to serious complications, which can occur for a variety of reasons:
   A. It is impossible to accurately verify gestation electronically and unfortunately, the later the pregnancy, the higher the risk of complications.
   B. In some cases, women are unable to access follow-up care.
   C. A leaked email sent by a Regional Chief Midwife at NHS England and NHS Improvement on the 'escalating risks' of the 'Pills by Post' service provides some examples of serious complications:
      - There are 3 police investigations linked to late 'DIY' home abortions, including a 'murder investigation as there is concern that the baby was live born'.
      - A woman at 32 weeks of pregnancy was able to receive 'DIY' home abortion pills (this was 'a near miss', as the 'woman had received the pills by post and then wished for a scan so attended a trust, and was found to be 32 weeks' pregnant).
      - There have been incidents involving the 'delivery of infants who are up to 30 weeks gestation'.
      - Women had to attend the Emergency Department for a range of incidents including 'significant pain and bleeding related to the process through to ruptured ectopics', and 'major resuscitation for major haemorrhage.'

- A further 13 incidents were under investigation (specifically, the email notes that the body who would investigate these matters, the CQC, 'are aware of 13 incidents related to this process').

Notably these are likely only the 'tip of the iceberg' of similar incidents across England, Wales and Scotland since the temporary orders were sanctioned nearly a year ago and given the incidents highlighted here occurred in just one region over a two-month period alone.

2. **Underreporting of medical complications**

It seems highly likely medical abortion complications are going unreported across England and Wales:

- The Department of Health and Social Care data show only one complication following a 'DIY' home abortion (out of a total of 23,061 abortions) during the period April to June 2020 for the whole of England and Wales.
    - Unbelievably, this would mean that the average rate of complications for medical abortions for similar gestations (3-9 weeks) over the past five years was over seventeen times higher than the complication rate for 'DIY' home abortions earlier this year, which seems highly unlikely.
- Out of 67,256 medical abortions where one or both pills were taken in clinic, there were 114 reported complications between January and June.
    - Again, it seems highly unlikely that the complication rate would be drastically lower when a woman is away from a clinic - it is more likely that complications are not being reported.
- The consultation paper itself acknowledges the official data on complications from the 2019 Abortion Statistics for England and Wales "is incomplete" as "It is not possible to fully verify complications recorded on abortion notification forms and complications that occur after discharge may not be always be recorded. For example, for terminations in 2019 where misoprostol was administered at home, complications may be less likely to be recorded on the abortion notification form."
- The Royal College of Obstetricians and Gynaecologists' Clinical Guidelines for Early Medical Abortion at Home corroborate this likelihood, noting that "When completing the Abortion Notification (HSA4) form, [...] Section 4dii ('date of treatment with prostaglandin') should be recorded as the date on which you advise the patient self-administers misoprostol."
- Given the provider may fill out the form before the woman has actually self-administered misoprostol (that is, the woman may not immediately take the medication at home), and indeed abortion provider BPAS themselves recently found that some women wait more than a week after receiving mifepristone and misoprostol before using them, it seems highly unlikely that all complications would be noted on the form, as complications could occur after the misoprostol is taken and could occur later than anticipated.

That 'DIY' home abortion complications are less likely to be recorded on the abortion notification form is incredibly concerning and indicates there is a severe gap in the evidence base for considering whether to make 'DIY' home abortion permanent.

3. **Risk of coercion and inability to identify domestic abuse**

'DIY' home abortions present a high risk of potential coercion and abuse.

- In an expert witness statement for a UK Court of Appeal legal challenge against 'DIY' home abortions, a longstanding GP and honorary clinical lecturer at the University of Birmingham, Dr Gregory Gardner, said, "[I]t will be difficult if not impossible to verify by phone or video whether a woman is undergoing any kind of duress to have an abortion. There does not seem to have been any consideration given to this in the proposed change in policy. There will be women who need delicate counselling to discover coercion or other forms of abuse."
- The Government itself expressed this concern in March, with Lord Bethell stating: "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."
- Some women may be unwilling or unable to contact medical providers for assistance after suffering complications from 'DIY' home abortions if they are in an abusive or controlling relationship. One 39-year-old woman for example, after suffering from significant complications, revealed she was unable to ring for advice in the presence of her partner, whom she described as 'very controlling'.

4. **Impossible to accurately verify gestation remotely**

- A recent investigation comprising several 'mystery clients', led by public health consultant Kevin Duffy, a former Global Director of Clinics Development at Marie Stopes International (now MSI Reproductive Services), revealed women can easily obtain abortion pills even when beyond the legal time limit for 'DIY' home abortion, as the mystery client 'Anna' from Sussex found.
    - 'Anna' "made her first call to BPAS and provided a date for her last menstrual period which on the day of that call meant that she was GA [gestational age] 8 weeks and 5 days." However, fearing that she may not obtain the pills as she may be beyond the legal limit by the time she received the abortion pills, during her second call (the consultation) when she "was again asked for her LMP [last menstrual period] [...] this time she gave a date which was two weeks later, [...]. Anna received the treatment pack [...]"
- Tragically, there are several known cases in which women in England have received abortion pills far beyond the legal limit.
    - Since the temporary order was put in place, one woman was able to receive abortion pills at 32 weeks' gestation.
    - Media reports in May (from the *Daily Mail* and *The Sun*) revealed that police in England were investigating the death of an unborn baby after

the mother took 'DIY' home abortion pills while 28 weeks' pregnant. One article states, "[t]he woman was four weeks past the legal termination limit in England and 18 weeks past the ten-week limit for taking the abortion pills at home under new measures." Tragically, "the baby was stillborn."
    - Media reports made it known that abortion provider BPAS are investigating 8 similar cases of 'DIY' home abortions occurring beyond the ten-week limit, raising serious questions regarding the level of clinical supervision to ensure that abortions are legal and safe.
- A recent Freedom of Information request revealed that between January and June 2020, 12 'DIY' home abortions past ten weeks' gestation were performed where both sets of pills were taken at home (as reported by HSA4 forms, though as noted in question 2 it seems likely this is actually higher given the likelihood of underreporting).
- NICE guidance suggests if an ultrasound is not performed, in-person follow up would be required, stating that
    - "Services providing surgical abortion before ultrasound evidence will need to have systems to confirm that the pregnancy has been aspirated. For example, they will need to have staff trained to inspect the products of conception for the presence of chorionic villi and a gestational sac [...] or immediate access to ultrasound. **Services offering surgical *or medical abortion before ultrasound evidence of pregnancy will also need to be able to assess serum human chorionic gonadotrophin (hCG), and have staff trained in interpreting test results***." [emphasis added]. In order for this to take place, it seems the woman would need to attend a clinic, which seemingly defeats the purpose of the temporary COVID-19 order to allow abortion to occur at home. On the other hand, the lack of such in-person follow-up to assess the outcome of the abortion surely diminishes the level of care received by the woman to an unacceptable extent.

5. Risk of complications increases as gestation increases

The only way to fully verify gestational age is via an ultrasound or in-person examination as, intentionally or unintentionally, women may provide an inaccurate date for their LMP (last menstrual period).

- This places women's health and safety at risk, for the rate of complications and the rate of hospitalisation for complications increases with gestational age. BPAS' own website, for example, notes that the number of women needing surgical treatment for incomplete abortion more than doubles from 3% at 9 weeks and under, to 7% at 9-10 weeks.
- Other studies suggest the rate of women needing surgical intervention may be higher:
    - A 2018 study found 12.5% of women at 9 weeks' gestation and below required surgical intervention to complete their medical abortion.

[Note: The 12.5% figure is based on the women who confirmed their intake and provided information in the follow-up evaluation.]

- A Finnish study of over 18,000 women found an 8% rate of surgery for medical abortion failures in the first trimester, which more than quadrupled to an almost 40% surgery rate in the second trimester. Though not referring to needing surgical treatment alone, another 2018 study found that among medical abortions under 12 weeks' gestation, "the complication frequency increased significantly, from 4.2% in 2008 to 8.2% in 2015". For this concerning increase in complications the study suggests: "the cause of this is unknown but it may be associated with a shift from hospital to home medical abortions."
- A 2019 review of telemedicine for medical abortion concludes that surgical evacuation rates are higher for medical abortion through telemedicine than for in-person abortions.

It also seems highly likely the actual complication rate is higher than reported given that, as the consultation paper notes, the official data on complications from the 2019 Abortion Statistics for England and Wales "is incomplete" and, "for terminations in 2019 where the second EMA pill was administered at home, complications may be less likely to be recorded on the abortion notification form."

Finally, the WHO's Medical management of abortion guideline (2018) states, regarding how one determines gestation, a "physical examination to assess uterine size [...], assessment of last menstrual period (LMP) and recognition of symptoms of pregnancy are usually adequate." No evidence has been given in this consultation paper to suggest these in-person medical checks are no longer important for women's health.

6. **It is not guaranteed that recommended protocols for taking abortion pills will be followed.**

The inability to remotely verify an accurate gestational date may result in a patient applying misoprostol in a manner unrecommended for their health, inviting the possibility of further medical complications. Furthermore:

- A review of patient adherence to treatment found that "poor compliance is to be expected in 30–50% of all patients, irrespective of disease, prognosis or setting".
- There is a distinct lack of high-quality research study designs that lack bias in existing data on unsupervised home abortion, as noted in the Cochrane Systematic Review 2020, which concludes "[I]t remains unclear whether self-administration of medical abortion is effective and safe."

7. **Testimonials from women suffering significant complications following negative experiences of 'DIY' home abortion**

- A 39-year-old woman suffering from significant complications after a 'DIY' home abortion and unable to ring for advice in the presence of her 'very

controlling' partner described the process of her medical abortion to the *Daily Mail*, stating that she thought she 'was going to die' on experiencing intense pain, cramps, vomiting and feverish symptoms after taking abortion pills at home.

- Another woman, Courtney Barnes, 27, still tested positive for pregnancy after taking abortion medication at home. She disclosed to the *Daily Mail* that "'You do pass a lot of blood [...] [i]t was a lot worse than I'd expected. The pain, the physical process was horrible." The article further describes how "[t]here was no routine follow-up call with a doctor or nurse to check how things had gone, just a text a couple of weeks later reminding her to use her pregnancy test."
- Another woman, a nurse in her 30s, was interviewed by *The Sunday Telegraph* under condition of anonymity. She claims that, at around five weeks' pregnant, she was informed by an abortion provider (MSI Reproductive Choices) "that the pain would be no more than a bad period pain and that 98% of women do not experience complications." Yet after taking 'DIY' home abortion pills, she felt like she was "going to die" and had heavy bleeding that continued for ten days.
    - The woman further claims the abortion provider failed to provide follow-up care; specifically she "was told that their counsellors are busy and she cannot get an appointment." Yet a hospital visit revealed she still had "products of conception inside her", and she has since had surgery.
    - She notes that she was "quite shocked that the UK, with all of our research and expertise would approve this [...] I'm horrified that in a country where there's a lot of domestic abuse going on that we could allow a system that could give this pill that could either force someone to miscarry, there's not enough checks [...]"
    - The woman said that she is struggling to return to work and that she now suffers from PTSD, and she is calling for women in crisis pregnancy to be properly assessed, "rather than being rushed through a process which leaves them traumatised for the rest of their lives."
- BPAS themselves note in their evaluation that 8.4% of women said they were dissatisfied with pain management.
- A 2018 study assessing the safety and acceptability of medical abortion through telemedicine after nine weeks' gestation found that just over one third of women, regardless of gestational age, reported their rate of pain was higher than expected.
- 45.6% of women reported their rate of bleeding was higher than expected at 9 weeks' gestation or under, increasing to 57.8% for women over 9 weeks' gestation.
- Clearly, allowing women to access 'DIY' home abortion after a phone call rather than requiring an in-person consultation places women's health and safety at risk.

8. **Potential public health risks from expelling an abortion at home**
    - The RCOG website states, under its 'Disposal following Pregnancy Loss before 24 Weeks of Gestation (Good Practice No. 5),' that abortion providers should follow the Human Tissue Authority (HTA) guidance on the "disposal of pregnancy remains following pregnancy loss or termination" which notes: the "woman should be made aware that there are options for disposal."
    - The Royal College of Nursing's document, referring to the HTA guidance, states it "acknowledges that women may choose to make their own arrangements, or to have no involvement with regard to disposal at all. The emphasis within the HTA guidance is on the woman's choice." Indeed, the woman can express choice in that she "may wish not to know about the disposal of the pregnancy remains or be involved in decisions about disposal."
        - Yet 'DIY' home abortion does not allow for such discretion in disposing of the fetus, as the woman is left with no option other than to dispose of her pregnancy herself.
        - As the BPAS webpage *Pills by Post - Abortion Pill treatment at home* states, "You can decide how you wish to dispose of the pregnancy remains. They [fetal tissue or 'pregnancy remains'] can be flushed down the lavatory or wrapped in tissue, placed in a small plastic bag and put in the dustbin."
    - This seemingly violates RSOP (Required Standard Operating Procedure) 15 of the *Procedures for approval of Independent Sector Places for Termination of Pregnancy (Abortion)* which states "the registered person must prepare and implement appropriate procedures to ensure that fetal tissue is treated with respect." The flushing away of fetal remains hardly seems respectful.
    - Dr Calum MacKeller, Director of Research of the Scottish Council on Human Bioethics recently noted that with home abortions, "*appropriate and sensitive respect for the disposal of the remains of the embryo/foetus does not generally take place since these are usually flushed down the toilet or discarded as waste in another manner. An outcome which may cause considerable distress to some vulnerable women having an abortion as well as the persons supporting them at home. This may happen because of their possible grief, especially when they see the dead embryo/foetus, which is up to 3-6cm in size at about ten weeks of gestation and which ends up in the sewage.*"

9. **Polling shows women are concerned about the safety of women undergoing abortion**
    - Recent polling from ComRes show that women want more, not fewer, safeguards around abortion across a number of key areas.
        - 77% of women agreed that doctors should be required by law to verify in person that a patient seeking an abortion is not under pressure from a third party to undergo the abortion.
        - A poll from March 2014 showed that 92% of women agreed that a woman requesting an abortion should always be seen in person by a qualified doctor.

- An opinion poll undertaken by ComRes in Scotland from January 2021 shows that an overwhelming majority of the general Scottish public, especially women, are concerned about the safety and legal issues arising from 'DIY' home abortion. By comparison, privacy and comfort - key arguments used by proponents for telemedicine abortion - were lower priorities for women.
    - 71% of women said they were concerned about women undergoing an abortion at home.
    - 85% of women were worried about women having a medical abortion beyond ten weeks of gestation, given that risks of complications from medical abortions increase with gestational age.
    - 87% of women were concerned about women being at risk of being coerced into an abortion by a partner or family member during the home abortion process where a doctor does not see the woman in person.
    - 80% of women were concerned by the possibility of abortion pills being falsely obtained for another person.

While the survey only covered Scotland, polling on the abortion issue in the past has shown similar opinions on this issue across England and Wales, so it is likely that public opinion on this issue is similar in England.

Question 2

2. Question: 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?**

Yes it has had a positive impact	
Yes, it has had a negative impact	**x**
It has not had an impact	
I don't know	

Points that can be included in the optional comments section:

1. **Women's health is of far greater importance than accessibility and convenience, and 'DIY' home abortion endangers women's health.**
   Accessibility should by no means be a key criterion for deciding whether or not to make 'DIY' home abortion permanent. Even if one were to argue that it is more easily accessible, the risks involved to women's well-being far outweigh any supposed benefits of easier access to abortion.

2. **Abortions are being performed earlier as part of a longer-term trend, not necessarily as a result of the accessibility of 'DIY' home abortion.**
    - The consultation paper notes that "Since 2009, there has been an increase in the proportion of abortions that are performed under 10 weeks. In England and Wales in 2019, 82% of abortions were performed under 10 weeks, increasing from 75% in 2009."
    - While the English Consultation Paper does not seem to directly link a reduction in gestational age for medical abortion to 'DIY' home abortion, I believe it is important to more fully address this issue.
        - First, there is no way to know whether or not all the 'reported' gestations are accurate. It is impossible to fully verify gestational age apart from an ultrasound or in-person examination. Also women self-reporting are likely to be under duress, finding themselves with an unwanted pregnancy in the time of a global pandemic, and may be providing, intentionally or unintentionally, incorrect information on their gestation.
        - Even if one were to accept the reliability of the data, the data itself do not fully support the claim that the temporary arrangements for 'DIY' home abortion have led to women having earlier medical abortions. While it shows 86% of abortions between January and June 2020 were performed at under 10 weeks, compared to 81% for the same period in 2019, the introduction of 'DIY' home abortion has not significantly shifted the prevailing trends in abortion practice but reflects an existing long term trend towards a higher percentage of abortions occurring at under 10 weeks' gestation, with a similar yearly percentage increase over several years, as demonstrated by a graph from the Department of Health and Social Care (https://www.gov.uk/government/publications/abortion-statistics-during-the-coronavirus-pandemic-january-to-june-2020/abortion-statistics-for-england-and-wales-during-the-covid-19-pandemic, figure 3). It therefore does not justify the extension of the telemedicine abortion scheme on this ground.

3. **Negative impact for vulnerable populations who have difficulty utilising the technology needed for 'telemedicine'**
    - While the abortion lobby and proponents for 'DIY' home abortion argue that women in domestic abuse situations should be able to access abortion remotely, firstly, they may not in fact be able to privately access services, given an abuser could always be in the background of a video or phone call. Furthermore, this argument merely enables an abuser to keep tight control over an abused victim, rather than making a way for the victim to escape her situation.
    - Not all individuals are able to access telemedicine. A recent report entitled 'Delivering core NHS and care services during the pandemic and beyond' drew upon numerous expert organisations in the field, including Rethink Mental

Illness, who "claimed that clinical appointments and community services which are now taking place online have become less helpful to patients."
    - The report referenced the Blood Cancer Alliance, who "suggested individuals whose first language is not English have found it harder to follow online guidance and videos."
    - While overall there are mixed results as it pertains to 'tele-health' it seems clear that it has a disproportionately negative impact on accessibility for the most vulnerable populations.
- Another expert organisation, Mind, drew attention in the same report to those with mental health problems and those with disabilities as being disproportionately excluded by telemedicine, and suggested that individuals **may not be in an environment where they are safe to talk about their mental health**. Indeed some women would likely need far greater support (advice, counselling, etc.) than a simple phone call provides.

4. **In-person checks are crucial to provide the highest standard of care for women, not least those suffering from mental health issues or domestic abuse, and to prevent abusers from accessing these pills**
    - In efforts to make these services more accessible for women, the current order has made abortion pills easier for abusers to access as well.

Question 3

3. Question: 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?**

Yes it has had a positive impact	
Yes, it has had a negative impact	**x**
It has not had an impact	
I don't know	

Points that can be included in the optional comments section:

1. **Risk of coercion due to lack of privacy**
    - 'DIY' home abortions present a high risk of potential coercion given that it is impossible to verify a women is in a private place during a remote

consultation. Anyone - a family member, friend or abuser - could intentionally or unintentionally overhear the phone or video consultation, infringing on the woman's privacy and confidentiality.

2. **Risk of inability to identify domestic abuse due to lack of privacy**
    - A testimony from Clinical Geneticist Dr Melody Redman on 'DIY' abortion summarises this issue well: *"[...]As a doctor, I have conducted video and telephone consultations where somebody else's voice suddenly pipes up, during what was supposed to be a private consultation. An abusive or manipulative partner could be sitting next to the woman and intimidating her through the whole video consultation without the doctor ever really knowing. Face to face consultations give women the safety, the space, and the specialist assessment to best support her at this difficult time. [...] Continuing remote consultations may be easier for abortion providers, but may do a great disservice to women."*
    - It is worth also noting the testimony of Sir Robert Neill MP, Chair of the Justice Select Committee and criminal practitioner, who stated during a Commons debate on amendments to the Domestic Abuse Bill, that "*I found instances where part of the abuse had been to force the victim to have an abortion. The irony is that reliance on a telephone call to procure the means of doing that does not give the safeguard of knowing who is standing next to the victim when she makes the telephone call."*
    - Given that domestic abuse and coercion remain ever-present threats to women's health and safety, perhaps especially in the midst of a pandemic and associated lockdown measures, it seems entirely unreasonable to diminish such a substantial safeguard by removing the protection of women's privacy and confidentiality that comes from an in-person consultation.

Question 4

4. Question: 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.**

Yes it has had a positive impact	
Yes, it has had a negative impact	**x**
It has not had an impact	
I don't know	

Points that can be included in the optional comments section:

1. **The framing of this question seems biased**

- By citing 'greater workforce flexibility, efficiency of service delivery, value for money' as examples, the question characterises the remote provision of abortion services as simply a matter of relative convenience and efficiency and encourages the reader to consider the impact of the temporary measure on these variables, though many others are far more important to women's health and safety.

2. **Potential negative impact on the health professional/patient dynamic**
    - The phrasing of the question excludes reference to the fundamentally altered relationship between health professionals and patients created by the lack of any in-person consultation, which would have a negative impact on the health professional:patient dynamic.
        - For example, research on nonverbal communication suggests that important aspects of our communication are nonverbal. A journal article on this finds that "focus on verbal communication overlooks the essential role nonverbal signals play in the communication of emotions, which has significant effects on patient satisfaction, health outcomes, and malpractice claims." This highlights the risk that attitudes communicated verbally and through body language may differ, and as such, telephone or video calls may hinder communication between patient and medical practitioner.
        - This is accentuated in cases where there may be a language barrier, wherein the Registered Medical Practitioner and patient may not be confident that they have understood each other and that the patient has provided fully informed consent for such an important decision.

3. **Unclear whether abortion providers are able to ensure women are not being coerced into abortion.**
    - In a debate on an amendment proposed to the Domestic Abuse Bill to allow women in domestic abuse situations to access telemedicine abortion, a doctor was quoted saying "[telemedicine abortion] would place doctors in a very risky situation. Deciding whether a patient might be in an abusive situation by one telemedicine consultation would be almost impossible [...] Assessment of women at risk of domestic abuse should be part of a comprehensive safeguarding strategy—it should not be left to a single doctor working under time pressure, via the medium of telemedicine."
    - In the same debate, a female GP was also quoted as having stated, "It is extraordinary that it should be argued that a woman suffering or at risk of domestic abuse, seeking abortion should somehow be considered to be at less risk if she consults a doctor remotely by telemedicine and given abortifacients to take at home. Where is the opportunity to check with her, privately, that she is not being coerced or that she may be in danger, to examine her to determine her stage of pregnancy, to offer support and clear advice in a place of safety? [...] These factors are virtually impossible to verify without a face to face consultation."

- In the event of inconsistent or contradictory communication, research shows body language (such as eye contact and facial expression) and tone of voice can be effective indicators of meaning and emotions. Phone calls, therefore, are ultimately unhelpful for resolving communication difficulties with patients, particularly in the case of 'DIY' home abortion when women might possess a combination of conflicting emotions and thoughts around the decision.

4. Expediency is the wrong measurement for a life-changing decision such as abortion where the effects can last a lifetime

- As many women struggle with the decision of whether to abort, it is vital that women are offered independent counselling and provided with a consideration period of 48 hours - rather than being rushed through a life-changing process that offers minimal personal engagement.
- 93% of women agree that a woman considering abortion should have a legal right to independent counselling from a source that has no financial interest in her decision.

Question 5

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

Yes	**x**
No	
I don't know	

Points that can be included in the optional comments section:

1. **Focuses attention away from battling COVID-19**
   - Treating complications for 'DIY' home abortion provision may pull medical professionals away from the frontlines of fighting COVID-19. In a time of an unprecedented global health crisis, needlessly placing women at risk of surgical procedures, potentially drawing medical professionals away from battling the pandemic, seems not only reckless but unethical.

2. **Possible increased pressure on emergency departments**
   - Notably, the BPAS remote EMA treatment guide states "Telephone 999 for an ambulance if you experience any of the following [...]", and lists several distressing complications. Given that women are instructed by abortion providers to go to hospital if they have concerns on these distressing complications, there is likely increased pressure on emergency departments,

as in these cases it is not the abortion providers that are dealing with women who are self-reporting, but hospital and emergency staff.

- It is highly likely that many more complications are occurring that are failing to be reported (further clogging Emergency Departments / 111 call lines).
- A leaked email sent by a Regional Chief Midwife at NHS England and NHS Improvement on the 'escalating risk' of the 'pills by post' system noted that women had to attend emergency departments for a range of incidents following taking abortion pills at home. As these reported cases occurred within a time period of two months and in one region alone, they likely represent the tip of the iceberg of complications occurring across the country that could potentially lead to increased pressure on emergency departments.

3. **Possible increased pressure on other public services**
    - 'DIY' home abortion has likely impacted public services such as the Care Quality Commission (CQC) and the police.
    - The police have already been tasked with investigating a case of late-term 'DIY' home abortion, as well as other cases, including one where there were concerns that the baby was live born.

Question 6

6. Question: **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?**

Points that can be included in the optional comments section:

1. **Information should be given to women around the risks of increased complications in later gestations and the severity of symptoms:**
    - Concerningly, this question appears to acknowledge that the temporary measure to allow 'DIY' home abortion is flawed as it cannot guarantee the accurate determination of gestational date (for which an in-person exam or ultrasound is needed), and may lead women to receive and take abortion pills beyond 10 weeks' gestation.
    - If any risk exists that pregnancies 'may potentially be over 10 weeks gestation' - as this question acknowledges - then women should not be provided with abortion pills, given the inherent safety risks involved.
    - It is vital to calculate gestational age accurately to "ensure women take the recommended dose and regimen of medications, and in the appropriate setting;" however the only way to verify this is via an in-person consultation.

- Inaccurate gestational estimates may lead to later-term abortions, such as in the case reported by the *Daily Mail* in May 2020 of a woman taking abortion pills at 28 weeks.
- The rate of hospitalisation for complications increases with gestational age; for example, a study of 18,000 women found an 8% rate of surgery for medical abortion failures in the first trimester, and an almost 40% surgery rate in the second trimester.
- A 2018 study assessing the safety and acceptability of medical abortion through telemedicine after nine weeks' gestation found that over one third of women, regardless of gestational age, reported their rate of pain was higher than expected.
- 45.6% of women reported their rate of bleeding was higher than expected at 9 weeks' gestation or under, increasing to 57.8% for women over 9 weeks' gestation.
- Vaginal bleeding or spotting lasts on average 9-16 days following a medical abortion.

2. **Information should be given to women regarding the type and incidence of medical complications:**
    - The most common complications from medical abortions under 12 weeks have been found to include: ongoing viable pregnancy (1.1%), heavy prolonged bleeding (15.4%), infection (1.2%), and gastrointestinal discomfort (50%).
    - A 2018 study found 18.3% of women required further treatment after a medical abortion through telemedicine at 9 weeks or under, and 29% of women at over 9 weeks' gestation.
    - Teratogenic effects such as clubfoot, limb and cranial nerve abnormalities have been reported in pregnancies that continue to birth following the taking of misoprostol.
    - Mifepristone and misoprostol should not be used in cases where there is a "Known or suspected ectopic pregnancy" (as noted in the Scottish consultation paper on 'DIY' home abortion.)
        - Tragically, a 2005 study confirming the deaths of five women after taking medical abortion pills found that four of these deaths were specifically "due to endometritis and toxic shock syndrome associated with *Clostridium sordellii"* and one "whose death was attributed to a ruptured ectopic pregnancy."
        - A leaked email sent by a Regional Chief Midwife at NHS England and NHS Improvement on the 'escalating risk' of the 'pills by post' system revealed that women had to attend the Emergency Department for a range of incidents including 'ruptured ectopics'.
        - As it relates to 'DIY' home abortion, it is impossible to confirm ectopic pregnancies via a phone call as it is possible to have an asymptomatic ectopic pregnancy. Hence, while ectopic pregnancies are rare, ultrasounds should be standard practice before medical abortion.

        - Further demonstrating the importance of routine ultrasound to diagnose ectopic pregnancies, a study published in January 2021 found a higher rate of women presenting with ruptured ectopic pregnancies during the COVID-19 pandemic (58% vs. 17% previously).
    - In 2018, Irish Minister for Health Simon Harris and the chair of the Institute of Obstetricians Peter Boylan, who have supported abortion access, noted "there are significant dangers to the unsupervised use of abortion pills." Peter Boylan further noted, "We have knowledge of women who have taken them in excessive dosage and that can result in catastrophe for a woman such as a rupture of the uterus with very significant haemorrhage [...] And if that happens in the privacy of a woman's home [...] that can have very, very serious consequences for women. So it's really important that these tablets are regulated and licensed, and dealt with in a supervised way in the interests of the health of women [...]".

3. **Information should be given to women regarding potential mental health complications:**
    - Anecdotal evidence shows that the psychological risks associated with medical abortions completed at home can be severe, partly because women usually see the fetus, which they then have to flush away themselves. Moreover, the reminder of the abortion is always in the home, not in an anonymous clinic that can be left behind.
        - Indeed, a 2020 systematic review funded by the National Institute for Health and Care Excellence (NICE) concludes with the recommendation that the NICE guideline on abortion care should explain for women who are having a medical abortion: "That they may see the products of pregnancy as they are passed" and "What the products of pregnancy will look like and whether there will be any movement."
    - Research suggests that mifepristone may have direct pharmacologic effects that increase risk of mental health issues and complications such as infection. Mifepristone also releases inflammatory cytokines that have been implicated in causing depression.
    - The BBC recently reported on the serious trauma incurred by some women forced to make a decision to abort without much-desired face-to-face counselling. Though it is unclear whether the abortion was a home or in-clinic abortion, the story illustrates that the mental health of women seeking abortion can be quite fragile, and thus may require more nuanced care than an impersonal phone consultation. The BBC report notes that, "[u]nable to access the help she needed, she said the abortion had an effect on her physical and mental health: 'I really struggled for the first couple of weeks following the abortion, I was bleeding heavily, I had clots, it was really painful and I had no support. Looking after my two children with no-one to talk to, no-one who understood, and no post-abortion counselling, that was traumatic.'"

- In addition to the physical trauma she endured, a nurse who sought an abortion from abortion provider MSI Reproductive Services is experiencing mental distress. She shares that after reaching out to MSI Reproductive Services, "I don't believe that I was ok to make this decision. I don't believe I was properly checked or even cared about [...] **The counselling was not available when I needed it most** [...] Every day since, I have asked myself: 'why did I do it?' I was in shock. It was totally wrong for me" [emphasis added].
- Another woman commented "I didn't look [at the fetus] because I knew it would really upset me".
- Though the consultation paper notes that "Counselling is available on request," and RSOP (Required Standard Operating Procedure) 14 of the *Procedures for approval of Independent Sector Places for Termination of Pregnancy (Abortion)*, 'Post Procedure,' states that "counselling should be provided or refer women for support to make a decision if they request this," it seems providers are failing to ensure this requirement is upheld, even though they can outsource counselling if they so choose.
- These stories - and the failure to meet the requirement for counselling - are particularly concerning during the time of a pandemic, when mental health issues are on the rise.

4. **Information should be given to women regarding evidence showing that there are more complications following medical abortions than surgical abortions:**
    - A Finnish study of over 42,000 women receiving abortions under 9 weeks' (63 days') gestation found that the rate of complications was 4 times higher in medical than surgical abortions. Specifically, the rate of haemorrhage was found to be over 7 times higher for medical than surgical abortions, whilst the rate of surgical evacuation was over 3 times higher for medical than surgical abortions.
    - A 2019 review of telemedicine for medical abortion concludes that surgical evacuation rates are higher for medical abortion through telemedicine than for in-person abortion care.

5. **Women should be informed that medical abortions may present a greater risk to those who live in rural areas with more limited access to emergency services.**
    Women living in remote locations may lack such access in any convenient manner, and so, 'DIY' home abortion potentially places them in greater danger than before.

6. **Women should be provided with information regarding what informed consent entails, and that it entails the right to withdraw consent for abortion:**
    - Information given to women on the risks of accessing pills under the temporary measure should include the following from the General Medical Council Guidance on decision making and consent: "the potential benefits, risks of harm, uncertainties about and likelihood of success for each option, including the option to take no action."

- The guidance also notes the medical practitioner "should let patients know that they can change their mind at any time."

7. **Information should be given to women regarding evidence on fetal pain:** Research shows that it may be possible for the fetus to feel pain from as early as 12 weeks' gestation. The impact of medical abortion on fetal pain at this age is not known.

Question 7

7. Question: **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?**

Yes, benefits	**x**
Yes, disadvantages	
No	
I don't know	

Points that can be included in the optional comments section:

1. **In-clinic assessment is an essential part of the medical abortion procedure.** Removing it places women at risk of potential coercion and abuse, and denies the opportunity for medical professionals to verify that the woman seeking abortion is not being coerced. Indeed, studies have indicated a significant association between intimate partner violence and abortion.
    - A 2007 study of young Australian women found "partner violence is a strong predictor of termination and other reproductive outcomes among young Australian women."
    - A 2014 study of London clinics found that the rate of domestic violence among women undergoing abortion was six times higher than for women receiving antenatal care.
    - A 2010 study 2010 concluded that "clinical services requiring that women have the opportunity to meet privately with providers (i.e., without partners) should be mandated to ensure safety and autonomy regarding women's decisions."

2. **A recent mystery client investigation has revealed that 'DIY' home abortion "schemes are wide open to abuse."** Kevin Duffy, public health consultant and former Global Director of Clinics Development at Marie Stopes International (now MSI Reproductive Services), stated, "the investigation clearly demonstrates that abortion at home, by pills-by-post, is not safe, and on many occasions it oversteps legal boundaries without any proper scrutiny

[...] It is deeply concerning that the abortion industry has been allowed to take this service this far during an already highly vulnerable time for pregnant women."

- All eight 'mystery' volunteers were able to acquire the abortion pills mifepristone and misoprostol using false names, dates of birth and gestational dates.
- This is incredibly concerning, especially in the context of the legal requirement that two Registered Medical Practitioners (RMPs) certify the grounds for termination.
- It is not clear whether or how such practices are regulated under the 'DIY' home abortion policy and it seems, if it is possible for individuals to obtain pills in a deceitful manner, this requirement is not being upheld. Indeed, it is unclear what legal responsibility any two RMPs in these situations would have, which is surely a concern given the fewer barriers to accessing abortion pills under the remote 'DIY' service.
- To correctly identify women seeking 'DIY' home abortion as well as to ensure NHS funds are properly allocated, service providers should be required to collect and validate every woman's NHS number prior to their consultation.
- All women should be required to see a clinician in person and present identification prior to accessing abortion pills, to ensure they are provided to whom they are intended.
    - The RCOG itself places high value on verifying a woman's identity prior to her collecting a treatment package, if she chooses to do so in person. Specifically, the RCOG Guidelines: Coronavirus (COVID-19) infection and abortion care state that "'[...] if a woman would like to collect her treatment package, this should be done with minimal contact and from a reception area following assurance of identification."
    - Not only does this raise questions of whether an ID check is mandatory when posting the pills, and how it would be performed, but also it still doesn't necessarily ensure the pills are received by the intended recipient.

3. **Even abortion provider MSI Reproductive Choices (formerly known as Marie Stopes International) emphasises the importance of private in-person consultation.**
   Their website declares that "[a]s part of an abortion appointment you would have a private consultation before treatment, away from any person who has accompanied you to the clinic. You can talk to our team in private and let them know what you are experiencing." (Such privacy can only be fully guaranteed in person.)

4. **Lack of a guaranteed private consultation (that is, an in-person consultation) is particularly concerning for minority ethnic women who come from cultures where women may be pressured into seeking a sex-selective abortion.**
   Several case studies from a Department of Health 'Assessment of termination of

pregnancy on grounds of the sex of the foetus' highlight the risk of abuse and pressure to abort based on the sex of the child.

5. The designated location for the abortion under the Approval of a Class of Places Act is meant to be the home, yet with 'DIY' home abortion, there is nothing to stop abortion pills being taken at other locations, or by other individuals.

- Self-administration of abortion pills removes any control over who takes the pills, where they are taken, whether they are taken, when in the process they are taken or if an adult is present.
- As a 2019 article in a leading medical journal states, "Potential for misuse and coercion is high when there is no way to verify who is consuming the medication and whether she is doing so willingly. Sex traffickers, incestuous abusers, and coercive boyfriends will all welcome more easily available medical abortion."
- Previous cases of abusers arranging forced abortions to cover up sex trafficking and the illegal supplying of abortion pills to underage girls highlight the possibility that the home abortion policy will make such abuse easier, through the misuse of home abortion pills.

6. The RCOG Guidelines: Coronavirus (COVID-19) infection and abortion care state that "clinicians must be confident the woman can speak privately without coercion," and "Providers need to ensure the woman has adequate privacy at the start of the consultation."

However, it seems clear that telemedicine provision cannot easily, if at all, ensure that abusers and other individuals seeking to coerce vulnerable women into abortion do not obtain abortion pills, which is a serious concern in the case of underage sexual abuse victims and those suffering from domestic abuse.

Question 8

8. Question: **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?

Points that can be included in the optional comments section:

1. Negative impact on pregnant women

- Prolonging the provision of medical abortion pills at home will negatively impact pregnant women as an equality group, as it presents great risk to women's physical and mental health (details outlined in other questions).

- Removing face-to-face consultations will negatively impact the consultation experience and decision-making process of women who would otherwise rely on in-person communication due to impaired hearing or vision, as well as those suffering debilitating mental health conditions and those exposed to coercion.
- Pregnant women are also more likely to suffer from domestic abuse, which has been on the rise during the COVID-19 pandemic. As the current temporary order allowing 'DIY' home abortion likely provides abusers with easier access to abortion pills, this places pregnant women at risk.

2. Disastrous impact on unborn children

- Recent figures released from the Department of Health and Social Care show that abortions in England continued to rise during the first six months of this year and are currently at an all-time high. This is a grave healthcare failing for the UK that denies the right to life of unborn children as a protected equality group.

3. Concerning impact on gender equality

- Given the availability of non-invasive prenatal testing, it is possible that a woman may learn the sex of her unborn child as early as 7 weeks. Tragically, it is quite possible that a woman, after receiving the results of this test, may choose to abort based on the sex of the child, and evidence suggests this is occurring in the UK:
    - A BBC investigation in September 2018 revealed evidence that new NIPT pre-natal tests are being used on a widespread basis to determine the sex of babies early in pregnancy and that women are coming under intense pressure to undergo sex-selective abortions.
    - The evidence was strong enough for Labour to call for a ban on NIPT for sex in 2018, as a preference for boys in some cultures, and the concept of 'family balancing', led to an increased termination of baby girls.
- An in-person consultation provides an opportunity for a trained medical professional to discuss the results and options in person. Without this safeguard in place, the provision to allow 'DIY' home abortion could see an increase in sex-selective abortion, which sends a cultural message to all women that somehow their lives are less valuable or worthy.

4. Worrying impact on medical professionals with religious affiliations

- Section 4 of the Abortion Act 1967 ensures any medical professional can conscientiously object to participating "in any treatment authorised by this Act", except that "which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman." Yet, as of now, it is unclear what would be considered participation in the context of the provision of 'DIY' home abortion.

Question 9

9. Question**:** 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?**

Points that can be included in the optional comments section:

1. **Equal access to an under-supervised, dangerous procedure is surely the wrong measurement of socioeconomic success**
    - 'DIY' home abortion may increase inequality in health outcomes experienced by socio-economically disadvantaged groups including homeless women, firstly with problems in accessing technology and a fixed postal address, and secondly as a missed opportunity to pick up on health issues that may not otherwise be addressed for women who are not undertaking routine GP check-ups.
    - Abortion rates are more than two times higher in the most economically deprived areas in England than the least deprived, according to Government data, implying that women in poorer areas are currently more at risk from unsafe 'DIY' home abortions under the temporary ruling.

2. **Equal access to an under-supervised, dangerous procedure is the wrong measurement of regional equality**
    - Pregnant women living in rural and isolated areas with limited access to healthcare are greatly disadvantaged by 'DIY' home abortions, which can result in severe discomfort and life-threatening complications.
        - To omit an in-person clinical consultation is to potentially miss serious issues that may threaten women's physical and mental health, such as an underestimated gestational date, an ectopic pregnancy, and evidence of coercion or abuse. Clearly remote consultations cannot be said to meet similar standards of care.
        - There is an obvious detriment to communication involved in removing physical interaction, particularly concerning more sensitive issues such as the detection of subtle signs of abuse or coercion.
    - Relying on the 'reasonable accuracy' of 'most' self-diagnoses of gestational dates is clearly inferior to the definite clarity of an in-person examination or ultrasound scan.
    - The Healthwatch Insight Report from June/July 2020 entitled 'The Doctor Will Zoom You Now' illustrates, some patients prefer in-person consultation rather than remote consultation, and notes that "an in-person appointment was felt to be best [...] where a physical examination or test is required and where confidentiality is essential."
    - These concerns are potentially greater in rural areas as, if a woman suffers complications, it will be much harder for her to gain access to emergency services being in a remote location, and therefore women should be required

to attend a clinic for the abortion procedure.The World Health Organisation's 'Medical Management of Abortion' guideline (2018) recommends that self-managed home abortion procedures are "an option in circumstances where individuals have a source of accurate information ***and access to a health-care provider*** should they need or want it at any stage during the process" [emphasis added], yet women living in remote locations may lack such access in any convenient manner.

- In sum, the permanent extension of 'DIY' home abortions presents disproportionate difficulties for those suffering social, economic, or geographical exclusion, especially during the physical restrictions of a pandemic response. The provision of telemedicine for 'DIY' home abortions may well also exacerbate existing inequalities in access to healthcare affecting groups such as those living in rural communities, those on the poverty line, those lacking technological access and aptitude, and the homeless, especially in the relative lack of in-person consultation during a pandemic. In-person consultation is significantly more appropriate than remote consultation in every case and therefore should be mandatory for all women.

Question 10

10. Question: Should the **temporary measure** enabling home use of both pills for EMA **[select one of the below]**	
Become a permanent measure?	
End immediately?	**x**
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?	
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?	
Other [please provide details]?	
Have you **any other comments** you wish to make about whether to make home use of both pills for EMA a permanent measure?	
Points that can be included in this optional comments section:	

1. **In-person care and involvement is in women's best interests and the temporary provision allowing women to administer their own abortions at home should end immediately.**
    - Both mifepristone and misoprostol should be taken in a clinic, to ensure they are taken properly, at the appropriate time and in the appropriate manner; but at the very least the first pill should be taken in clinic after an in-person exam for reasons outlined above.
        - Taking abortion pills in a clinic provides an added measure of safety for women so that, should they experience a complication, medical care is immediately accessible.
    - Even if one argues the risks of COVID-19 transmission outweigh the risks of telemedical abortion, there is no justification for keeping such a comparatively risky procedure in place once the COVID-19 restrictions have been lifted and in-person consultation returns to usual availability.

2. **The temporary measure places substantial medical responsibility on pregnant women undergoing 'DIY' home abortion, with potentially severe consequences in the case of error.**
    - Notably, the English Consultation Paper fails to provide as full coverage of the medical self-monitoring required by women under the current temporary arrangements as is provided in the Scottish Government's Consultation Paper. The English Consultation Paper only seems to refer to "written advice and information" provided in the treatment package for women. In contrast, the Scottish Consultation Paper informs its respondents that women are responsible for understanding and supervising their own 'symptoms of significant anaemia,' 'standard dosing interval,' and various other complex aspects of self-administration .
    - The English Consultation Paper is comparatively and strikingly silent on the complexity of medical self-administration involved in 'DIY' home abortion, and the inability to remotely verify an accurate gestational date may result in a patient applying misoprostol in a manner unrecommended for their health.

3. **Options presented have not received the 'validated impact assessments' advised by principle C of the UK Government's Consultation Principles 2018.**
    - Principle C states: "Consultations should be informative. Give enough information to ensure that those consulted understand the issues and can give informed responses. Include validated impact assessments of the costs and benefits of the options being considered when possible; this might be required where proposals have an impact on business or the voluntary sector."
        - Yet the consultation paper fails to provide examples of particular complications and concerns as a result of 'DIY' home abortion. Such examples would surely be relevant for assessing the safety and acceptability of 'DIY' home abortion in particular, yet the paper only provides the total rate of complications from abortions for 2019, when the temporary measure allowing 'DIY' home abortion was not in place,

admitting (as noted previously) that "this data on complications is incomplete," and further admitting that "where the second EMA pill was administered at home, complications may be less likely to be recorded on the abortion notification form."
    - The paper also fails to divulge that miscalculated gestational date and unrecognised abuse or coercion are particular challenges facing 'DIY' home abortion.
- Given the absence of critical information concerning the problems introduced by the implementation of 'DIY' home abortion, question 10 cannot be fairly answered by a respondent who has relied upon the consultation paper for 'validated impact assessments' of the competing options.

4. Criticisms of the consultation itself

- It is important to highlight areas of the consultation that concerningly may encourage biased submissions.
- The consultation paper states that "DHSC is monitoring how the temporary approval is working in practice through regular discussions with abortion providers and the RCOG and through emerging data and other evidence." It is concerning that this consultation is being managed through close work with organisations that have a financial interest in abortion.
- Misleading information in the consultation introductory notes is cause for concern, as the consultation paper states: "Remote consultation with healthcare professional. This follows the same standards as face-to-face consultations." This is inaccurate as it is not possible for remote consultations to follow the same safety standards as face-to-face consultations, by nature of being 'remote'; for example Registered Medical Practitioners are unable to verify that the women is alone (in a remote consultation someone could easily be listening in the background), and unable to verify the gestational age of the baby with an in-person check, or ultrasound if needed.
    - The consultation paper implies that self-diagnosis of last menstrual period is safe and accurate, yet it is not possible to verify gestation without an in-person examination, and relying on such estimates places the health of women at risk given that the risk of complications escalates as gestation increases. Furthermore, self-reporting is fundamentally insecure, especially when added to the risk of unrecognised coercion.
- Notably, the removal of the provision of ultrasound scans under 'DIY' home abortion seems unjustified.
    - In the response from Public Health England to a Freedom of Information request (FOI-1750) seeking correspondence between PHE and BPAS on abortion since the 1 March 2020, it was revealed that an unnamed BPAS official informed an unnamed PHE official by email on 10 March 2020 that "in order for this ['DIY' home abortion] to work as a proposal as you know it would draw very much on the plan XXXX talked to you about not performing an ultrasound for women less than 56 days who are sure of LMP."
    - It appears, then, that the introduction of 'DIY' home abortion rested on an attempt to stop ultrasound practice before 8 weeks' gestation, which until this

point it would seem had not been agreed on nor thoroughly vetted. Indeed, there is also a lack of clarification as to why this should become the new norm (it is not clear what "the plan XXXX talked to you about" is). Moreover, this correspondence suggests that 'DIY' home abortion was initially considered for the first eight weeks of pregnancy rather than up to ten weeks' gestation, which is an extension that seems hard to justify.

- The seemingly unjustified removal of the provision of ultrasound scans was further made evident when you compare the changing versions of the website for MSI Reproductive Choices. On 8th August 2020, the old website (Marie Stopes) declared that "we will assess how many weeks pregnant you are using ultrasound scanning" whereas from at least 30th November 2020, and currently, the new website states that "we may need to assess how many weeks pregnant you are using ultrasound scanning." There are no reasons given on the new website for why women who contact MSI Reproductive Choices for an abortion may no longer need ultrasound scans, and that this represents a change in practice is simply ignored.

5. Parliamentary questions and contributions

- Parliamentary contributions concerning the home use of abortion pills during the COVID-19 pandemic since the policy's introduction show that it has substantial Parliamentary opposition.
- As many Parliamentarians' constituents may not know about this consultation or be able to respond to it, but have made their concerns over 'DIY' home abortion known to their MP, it is important that these concerns raised in Parliament are also given due weight in this public consultation. For example, recent Parliamentary questions have highlighted MPs' and Peers' concerns regarding:

    - Medical complications from medical abortion:
        - https://questions-statements.parliament.uk/written-questions/detail/2020-10-30/109293
        - https://questions-statements.parliament.uk/written-questions/detail/2020-12-02/124108

    - Inquiries into the ongoing investigation of a maternal death from medical abortion:
        - https://questions-statements.parliament.uk/written-questions/detail/2020-12-02/124109
        - https://questions-statements.parliament.uk/written-questions/detail/2020-09-14/89878

    - The reporting of complications following a medical abortion:
        - https://questions-statements.parliament.uk/written-questions/detail/2020-12-30/132913
        - https://questions-statements.parliament.uk/written-questions/detail/2020-11-18/117182

        - https://questions-statements.parliament.uk/written-questions/detail/2020-06-03/54271

    - Monitoring safety of 'DIY' home medical abortions:
        - https://questions-statements.parliament.uk/written-questions/detail/2020-11-16/115492
        - https://questions-statements.parliament.uk/written-questions/detail/2020-10-30/109291

    - The lack of in-person consultation:
        - https://questions-statements.parliament.uk/written-questions/detail/2020-11-18/117181
        - https://questions-statements.parliament.uk/written-questions/detail/2020-11-18/117184
        - https://questions-statements.parliament.uk/written-questions/detail/2020-10-13/102945

    - 'DIY' home abortions occurring past the legal limit:
        - https://questions-statements.parliament.uk/written-questions/detail/2020-11-18/117180
        - https://questions-statements.parliament.uk/written-questions/detail/2020-11-16/115489

    - The accessibility of this consultation:
        - https://questions-statements.parliament.uk/written-questions/detail/2020-12-15/129947

- An amendment to the Domestic Abuse Bill in July 2020 aiming to make the 'DIY' home abortion provision permanent for women in domestic abuse situations also received severe criticism from across the political spectrum, with concerns raised by several MPs over safeguarding, privacy and abortion coercion.
    - Carla Lockhart MP noted that making 'DIY' home abortions permanent "makes no provision for helping women to get out of the abusive situation. Providing women with abortion pills while failing to address the reasons why women may be unable to safely to attend a clinic does not present itself as a responsible or logical solution to tackling domestic abuse. Our laws should be designed to help vulnerable women escape domestic abuse situations, not enable them to remain in those horrific situations."
    - Jim Shannon MP noted "In a context where article 39 of the Istanbul convention highlights the need to counter coercive abortion, does she [the Minister] agree that the proposal to allow women in domestic abuse situations unique permanent access to medical abortion, without needing to leave their abusive environment for a physical consultation, is nothing if not seriously misplaced?"

- It is evident from these (not exhaustive) examples of recent Parliamentary contributions on the issue of home abortion that the 'DIY' home abortion policy has received widespread criticism from some of our politicians, who hear from and represent the views of many of their constituents on this topic. In the spirit of a public consultation, these views should also be noted.

6. Devolved administrations have expressed caution over 'DIY' home abortions

- The Northern Ireland Department of Health has recently warned that 'women 'are at risk' if they choose to pursue do-it-yourself terminations.' Specifically, the Department believes "that services should be properly delivered through direct medical supervision within the health and social care system." *(Currently Northern Ireland does not permit the taking of both abortion pills at home.*)
- Safety concerns over 'DIY' home abortion have also been raised recently in the Welsh Parliament: https://record.senedd.wales/WrittenQuestion/80926 and in the Scottish Parliament: https://beta.parliament.scot/chamber-and-committees/written-questions-and-answers/question?ref=S5W-29604 and https://beta.parliament.scot/chamber-and-committees/written-questions-and-answers/question?ref=S5W-34609

7. Numerous media articles condemning the risks of 'DIY' home abortion highlight the substantial public concern since 'DIY' home abortions were introduced:

- Baroness Philippa Stroud, *Telegraph* (8/12/20): 'Permanently legalising home abortions is a terrible idea': https://www.telegraph.co.uk/news/2020/12/08/permanently-legalising-home-abortions-terrible-idea/
- Sally-Ann Hart MP, *Conservative Home* (29/1/21): 'Do-it-yourself home abortion puts women and babies at risk, and ministers should end it': https://www.conservativehome.com/platform/2021/01/sally-ann-hart-diy-home-abortion-puts-women-and-babies-at-risk-and-ministers-should-end-it.html
- *Daily Mail* (23/5/20): 'Police investigate death of unborn baby after woman took 'pills by post' abortion drugs while 28 weeks pregnant - four past the legal limit': https://www.dailymail.co.uk/news/article-8349739/Police-investigate-death-unborn-baby-woman-took-abortion-drugs-home-28-weeks-pregnant.html
- *The Sun* (22/5/20)*:* 'Pills by Post: Police probe death of unborn baby after woman has illegal 'abortion by post' at 28 weeks - four weeks past limit': https://www.thesun.co.uk/news/11690506/police-probe-death-of-unborn-baby-after-woman-has-illegal-abortion-by-post-at-28-weeks-four-weeks-past-limit/
- *Telegraph* (13/10/20): 'Nurse criticises judges over 'DIY abortion' ruling after 'excruciating pain' requiring surgery': https://www.telegraph.co.uk/news/2020/10/13/nurse-criticises-judges-diy-abortion-ruling-excruciating-pain/
- Dr Anthony Latham, *Daily Record* (14/10/20): 'Leading Scots medic fears risk to women's health by continuing DIY abortions' in the Daily Record: https://www.dailyrecord.co.uk/news/scottish-news/leading-scots-medic-fears-risk-22842921

- *Daily Mail* (18/11/20): 'Unplanned pregnancies. Months of crippling pain. And women left with little choice but to have a home abortion: As sexual health services collapse, the hidden toll of the covid contraception crisis': https://www.dailymail.co.uk/femail/article-8962933/As-sexual-health-services-collapse-hidden-toll-covid-contraception-crisis.html
- John Mason MSP, *Times* (17/12/20): 'Reducing abortion safeguards fails vulnerable women': https://www.thetimes.co.uk/article/reducing-abortion-safeguards-fails-vulnerable-women-0wb9rtn39
- Sally-Ann Hart MP, *Politics.co.uk* (16/1/21): 'Home abortions a "disservice" to women': https://www.politics.co.uk/comment/2021/01/06/home-abortions-a-disservice-to-women/
- Dr Calum MacKellar, *The Scotsman* (31/12/20): 'Think twice before making home abortions the new normal': https://www.scotsman.com/news/opinion/columnists/think-twice-making-home-abortions-new-normal-dr-calum-mackellar-3079699

Read together, the above articles clearly suggest there is no justification for keeping 'DIY' home abortions in place, especially once the COVID-19 restrictions have been lifted and in-person consultation returns to its usual availability.