

# **Engender response to the Scottish Government consultation on future arrangements for early medical abortion at home**

December 2020

## **1. INTRODUCTION**

Engender unequivocally supports women's autonomy over their bodies and lives, and considers abortion access fundamental to women's rights and gender equality. Access to safe abortion is essential for women's economic and social rights, to women's autonomy, employment, education and access to resources, and therefore to women's equality. In a gender-equal Scotland, all women must have a legal right to choices around family planning, which is supported by intersectional and gender-sensitive abortion services, adequate and culturally sensitive information and support and must be able to access care without intimidation, coercion, harassment or stigmatisation.

We therefore welcome this opportunity to respond to the Scottish Government's consultation on the future arrangement for early medical abortion (also known as abortion by medication or a medical abortion) at home. The use of 'telemedical' services across Scottish healthcare has fundamentally challenged notions of what is possible in healthcare design, and the introduction of telemedical abortion care has offered many women access to essential healthcare throughout the pandemic, while creating opportunities for more person-centred and patient-led options in abortion care.

## **2. ABORTION SERVICES IN SCOTLAND**

Abortion in Scotland remains highly paternalistic and stigmatised - subject to legal and service restrictions that do not apply to any other healthcare. Women experience a number of barriers to quality care, including the requirement for two doctors to certify the approval for an abortion, the need for multiple appointments and lack of available services for later abortion care in many local areas. This is despite abortion being the most common gynaecological procedure in the world, accessed by 1 in 3 women at some point in their lives. The World Health Organisation (WHO) has indicated that medical abortion in the first trimester can safely be managed by women and can take

place at home.<sup>1</sup> Women in Scotland deserve to be able to access world-leading care within the NHS.

Retaining telemedical abortion after the Covid-19 pandemic does not require a certain care pathway or type of treatment, but it enables women, with advice from their doctors and nurses, to make the right decision for them. We believe that maximising choice in accessing abortion services is a critical aspect of women's control over fertility, reproduction and human rights. The UN Committee on Elimination of Discrimination Against Women (the CEDAW Committee) considers "laws that criminalise medical procedures only needed by women" to be a form of discrimination.<sup>2</sup>

The introduction of Early Medical Abortion at Home (EMAH) allowed women to start abortion in a clinical setting by taking mifepristone in clinic and continue it in their home, where they can self-administer misoprostol to pass the pregnancy.

While for women ordinarily resident in Scotland this may reduce the number of appointments they must travel to and offers a choice about abortion care which reflects where she feels most comfortable and safe, it still requires women to attend in-person clinical appointments. Telemedical abortion services has proven that this is not a necessary element of quality abortion care. The service is safe, effective, and accessible – and enables women in Scotland to make the right choice for them regardless of geographic, economic, or social constraints. Research shows that both self-administration of medical abortion pills at home and telemedicine are highly acceptable to women and are effective, with high levels of satisfaction reported.<sup>3</sup>

To provide women with access to remote care only to withdraw it would reduce the quality and the accessibility of abortion care options in Scotland. As abortion is a common aspect of women's healthcare, it is also likely that removal of the services would represent a reduction in quality care provision, a move which would be incompatible with the principle of non-retrogression of human rights. The progressive realisation of economic, social and cultural rights requires a state to devote the maximum available resources the progressive realisation of the right, including the highest attainable standard of health.<sup>4</sup>

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<sup>1</sup> World Health Organisation (2014) Clinical Handbook for Safe Abortion, Available at <[https://apps.who.int/iris/bitstream/handle/10665/97415/9789241548717\\_eng.pdf](https://apps.who.int/iris/bitstream/handle/10665/97415/9789241548717_eng.pdf)>

<sup>2</sup> CEDAW (1999) General Recommendation No. 24: Article 12 of the Convention (Women and Health)

<sup>3</sup> Atey H. (2020) Countries' Covid-19 responses could debunk some myths around the 'abortion pill'. The Conversation. Available at <<https://theconversation.com/countries-covid-19-responses-could-debunk-some-myths-around-the-abortion-pill-136088>>

<sup>4</sup> CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12). Available at <<https://www.refworld.org/pdfid/4538838d0.pdf>>

We therefore set out in this consultation response the evidence that support the continuation of telemedical abortion services once the temporary cCvid-19 permission expires. Engender considers retaining the services the most desirable option for women’s health, safety and human rights.

### 3. CONSULTATION QUESTIONS

**1. What impact do you think that the current arrangements for early medical abortion at home (put in place due to COVID-19), have had on women accessing abortion services? Please answer with regards to the following criteria.**

**a) Safety**

**Positive Impacts.**

It is important to recognise that abortion is an extremely safe and extremely common procedure and that continuing a pregnancy generally presents greater risks to women’s health. We also know that placing legal restrictions on abortion healthcare does not reduce the incidence of abortion, but does push them later into pregnancy and increases risks for women.<sup>5</sup> It is therefore safer to facilitate earlier abortion to reduce potential, but exceedingly rare, risks to women’s health and the British Pregnancy Advisory Service (BPAS) has shown that the introduction of telemedical services in England resulted in a greater proportion of women having abortions before 7 weeks gestation between January and June 2020 compared to the same period in 2019 (50% compared to 40%).<sup>6</sup>

Research has shown that rates of continuing pregnancy, complete abortion, haemorrhage and hospitalisation reported with telemedical medical abortion care are similar to those reported in the literature for in-person abortion care.<sup>7</sup> Telemedical abortion allows women to choose the most convenient time to take medication and facilitate the most effective interval between the two medicines to maximise effectiveness and minimise the need for follow-up care.

The need to attend appointments in person may also have complications for women with coercive and controlling partners – particularly where they have to account for their time or travel, and victim-survivors of sexual violence and domestic abuse. One

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<sup>5</sup> TxPEP, University of Texas (2019) Change in second-trimester abortion after implementation of a restrictive state law

<sup>6</sup> BPAS (2020) Pills by Post: Telemedical Abortion at the British Pregnancy Advisory Service. Available at <<https://www.bpas.org/media/3385/bpas-pills-by-post-service.pdf>>

<sup>7</sup> M Endler,a,b A Lavelanet,c A Cleeve,a B Ganatra,c R Gomperts,d K Gemzell-Danielsson (2019) Telemedicine for medical abortion: a systematic review. BJOG.

study concerning a UK abortion clinic identified that 11% of women accessing the clinic had experienced physical abuse during the last year, and four per cent had experienced sexual abuse during the last year. Four per cent of women seeking terminations had experienced physical abuse during their current pregnancy.<sup>8</sup>

While concerns are often stressed about a link between abortion and violence against women, evidence from the British Society of Abortion Care Providers is clear that it is more common for men to control women's access to healthcare and abortion than to attempt to force her to have an abortion against her will. They further stress that abortion providers have protocols in place to ensure women can speak privately and that speaking to women over their own phone is more conducive to assessing risk than when an abusive partner is aware of or present at her in-person appointment.<sup>9</sup> Evidence from providers also indicates that women may in fact be more likely to disclose abuse when they can discuss it outside a clinic setting.<sup>10</sup>

We agree that routine inquiry over the phone is an important aspect of service delivery and that providers should continue to stress the availability of in-person appointments where there is any clinical or safety concern. However, the availability of telemedical care is in our view more likely to ensure privacy and autonomy for women who are living with an abusive partner.

## **b) Accessibility and convenience of services**

### **Positive Impacts.**

Telemedicine provides women with safe, effective and accessible abortion care and increases the care options available for women. Since 2003, the World Health Organisation has recommended that abortion care be provided at the 'lowest' appropriate level of the healthcare system.<sup>11</sup> It is a common and safe procedure that one in three women will utilise in her lifetime. Early Medical Abortion already accounts for around 80% of abortions every year in Scotland.

Women who face barriers to attending in-person such as inaccessible facilities or transport, cost of travel or the need to avoid being absent or manage care responsibilities are all likely to benefit from the flexibility and control of telemedical care. Because the pre-Covid rules for medical abortion at home required women to take the first pill (mifepristone) in the clinic and the second pill 24-48 hours later

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<sup>8</sup> Motta, S., Penn-Kekana, L., and S Bewley (2014) Domestic violence in a UK abortion clinic: anonymous cross-sectional prevalence survey

<sup>9</sup> British Society of Abortion Care Providers (2020) Submission to the Health and Social Care Committee Inquiry. Available at <<https://bsacp.org.uk/wp-content/uploads/2020/05/Submission-to-Health-Social-Care-Committee-on-Coronavirus-080520.pdf>>

British Society of Abortion Care Providers (2020) Submission to the Health and Social Care Committee Inquiry. Available at <<https://bsacp.org.uk/wp-content/uploads/2020/05/Submission-to-Health-Social-Care-Committee-on-Coronavirus-080520.pdf>>

<sup>11</sup> WHO (2003) Safe abortion: technical and policy guidance for health systems.

women had less choice about when they pass a pregnancy. A relevant consideration is the relative accessibility of illegal abortifacient medication online. Women resort to this course of action for a wide range of reasons, many of which relate to multiple and compounding inequalities.<sup>12</sup> Currently, those most in need of support are being pushed into a position where they risk prosecution by a needlessly onerous system. This adds further weight to the need for accessible, safe and legal abortion care which meets the needs of particular groups of women. Retaining telemedical services with quality support provided through the NHS has the potential to reduce the need many women feel to seek out alternative care.

### c) Waiting times

#### **Positive Impacts.**

Retaining telemedical services means that women do not have to visit in-person appointment unless they want or need to. Providers report that when women do have to visit a clinic for scans, their appointment times can be much shorter and women are not having to wait for long times in clinics for two doctors to sign the legal forms certifying that she meets the grounds for an abortion under the Abortion Act 1967.<sup>13</sup>

Evidence from BPAS relating to English clinics suggests that waiting times have fallen by more than a week, and same day treatments are now available as a result of telemedicine. Their data shows that waiting times for appointments have more than halved and that the average gestation at which women have their consultation has also fallen by over a week.<sup>14</sup>

We should also acknowledge disruption to women's access to contraception as a result of the pandemic. The Faculty of Sexual and Reproductive Health has noted that Long-acting reversible contraception (LARC) was extremely curtailed in NHS reprioritisation, and advice was given out to existing users on how the lifespan of devices currently in use can be extended.<sup>15</sup> We do not yet know how the impact of the pandemic has changed women's plans around children and pregnancy. This is reasonable grounds to expect at least some increase in need for abortion services in the short to medium term.<sup>16</sup>

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<sup>12</sup> Engender (2016) *Our Bodies, Our Choice: The Case for a Scottish Approach to Abortion*. Available at <<https://www.engender.org.uk/content/publications/Our-bodies-our-choice---the-case-for-a-Scottish-approach-to-abortion.pdf>>

<sup>13</sup> However, telemedical abortion does not change the requirement for two doctors to certify the pregnancy or the grounds for the abortion, which we continue to argue is paternalistic, unnecessary and a barrier to the realisation of women's rights.

<sup>14</sup> BPAS (2020) *Pills by Post*. Available at <<https://www.bpas.org/media/3385/bpas-pills-by-post-service.pdf>>

<sup>15</sup> FSRH (2020) *Essential SRH services during COVID-19* London: Faculty of Sexual & Reproductive Healthcare; Available at <<https://www.fsrh.org/documents/fsrh-position-essentialsrh-services-during-covid-19-march-2020/>>

<sup>16</sup> British Society of Abortion Care Providers (2020) *Submission to the Health and Social Care Committee Inquiry*. Available at <<https://bsacp.org.uk/wp-content/uploads/2020/05/Submission-to-Health-Social-Care-Committee-on-Coronavirus-080520.pdf>>

**2. What impact do you think that the current arrangements for early medical abortion at home (put in place due to COVID-19), have had for those involved in delivering abortion services? (For example, this could include impacts on workforce flexibility and service efficiency.)**

**Positive Impacts.**

Telemedical abortion care has enabled providers to continue to prioritise and ensure high quality services at a time when many other aspects of women's health including contraception, screening and maternity services have been negatively affected. NHS services have reported that telemedicine has enabled them to provide services when staff have been redeployed to deal with Covid-19, indicating that high quality abortion services can now be provided with fewer staff, and that this has allowed for more flexible management of clinics and more time can be spent delivering care to women who require more support.<sup>17</sup>

Engender has previously noted<sup>18</sup> the difficulty in improving access to and quality of abortion service design because of the functioning of the Abortion Act 1967, which prohibits full development of nurse or midwife-led services, which have been proven elsewhere to expand early access to abortion care, reduce waiting times for women undergoing the procedure, and increase flexibility in rural areas.<sup>19</sup> The World Health Organisation's guidance that abortion care be provided at the 'lowest' appropriate level of the healthcare system also recommends that and that vacuum aspiration can be provided by mid-level care providers, including nurses and midwives, in primary care facilities throughout the first trimester of pregnancy.

It is therefore extremely welcome that an opportunity for alternative improvements to services can be demonstrated with telemedical care, enabling women to control their abortion while maximising the service in-person for women who need or prefer it.

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<sup>17</sup> Atey H. (2020) Countries' Covid-19 responses could debunk some myths around the 'abortion pill'. The Conversation. Available at <<https://theconversation.com/countries-covid-19-responses-could-debunk-some-myths-around-the-abortion-pill-136088>>

<sup>18</sup> Engender (2016) Our Bodies, Our Choice: The Case for a Scottish Approach to Abortion. Available at <<https://www.engender.org.uk/content/publications/Our-bodies-our-choice---the-case-for-a-Scottish-approach-to-abortion.pdf>>

<sup>19</sup> Jejeebhoy et al (2011) Can nurses perform MVA as safely and effectively as physicians: evidence from India; Weitz et al (2013) Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives and physician assistants under a California legal waiver

**3. What risks do you consider are associated with the current arrangements for early medical abortion at home (put in place due to COVID-19)? How could these risks be mitigated?**

Engender believes that women's needs and wishes should be at the heart of reproductive healthcare. We therefore suggest that clinical risks associated with self-managed use of medication are best managed by clinical guidance as opposed to a legal restriction. As we have outlined above, services have already established and continue to build on approaches to managing non-clinical risk, such as the inclusion of routine inquiry and sensitive approaches to discussing domestic abuse via phone. Telemedicine enables women to access care where leaving the home would put them at further risk.

Abortion providers have also developed 24-hour advice lines and information that is sent out with the medications, often with pain management and oral contraception. Women, young women and girls, trans men and non-binary people that wish to consult healthcare staff should have access to intersectional advice and support that is sensitive to their specific needs.

**4. Do you have any views on the potential impacts of continuing the current arrangements for early medical abortion at home (put in place due to COVID-19) on equality groups (the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation)?**

**Yes.**

We have already set out our analysis that maximising the options for delivery of abortion care is likely to offer the most opportunity for tailored care that meets the needs of distinct groups of women. Developing services that are gender-sensitive and intersectional requires the experiences and realities of diverse groups of women to be understood as these factors shape the capacity and resource to access reproductive healthcare in specific ways. The design of services is critical in ensuring that every single person who needs it can access safe and free abortion.

Layers of procedure add complications for women with coercive and controlling partners, and victim-survivors of sexual violence and domestic abuse. Groups of women who face multiple inequalities when accessing healthcare also stand to be especially disadvantaged when engaging with services. For instance, disabled women, LGBT people and care-experienced women in Scotland report discrimination in accessing reproductive health services.<sup>20</sup> Women with insecure immigration status,

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<sup>20</sup> Evidence submitted to Engender's shadow CEDAW report 2018

adolescent girls (whose mental health is poorer than that of boys),<sup>21</sup> refugee, asylum-seeking,<sup>22</sup> migrant, learning disabled, and the Equality and Human Rights Commission has previously noted that older Indian, Pakistani and Bangladeshi women<sup>23</sup> also face particular economic, linguistic, social and practical barriers to healthcare and to good health.

Mothers, victim-survivors of sexual violence, women experiencing domestic abuse, young women and girls and homeless women are more likely to experience practical barriers to accessing in-person appointments. Women's greater provision of care and childcare may make travel to appointments more difficult or expensive. This is particularly acute where women are caring for a child with special needs. Cost of travel or taking time off work is likely to affect women with lower access to resources, including women of colour and younger women.

Research from Engender has shown that many disabled and learning-disabled women and girls experience infantilising treatment when accessing reproductive healthcare, note a widespread lack of accessible services and information, and lack consent and autonomy concerning reproduction and fertility. This lack of autonomy significantly restricts access to abortion and contraception, and can result in forced sterilisation.<sup>24</sup> Disabled women may also have different access needs that affect their capacity to visit hospitals and clinics in-person or mean that they have to forgo privacy in order to have support to access transport or even premises.

While abortion stigma is a problem for all women, women from some religious or cultural backgrounds may be particularly affected. This is likely to be worsened where women may have to walk past anti-abortion protesters at the clinic entrance. Research shows that access to abortion is still shaped by the interaction women have with the particular healthcare professions they encounter and that "significant effort is required for individuals to assert their candidacy for pregnancy or abortion services".<sup>25</sup> Women's capacity to exert that effort is likely to be affected by other experiences and forms of discrimination, including age, language, race, disability, experience of men's violence and health.

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<sup>21</sup> SAMH (2017) Going to be all right? A report on the mental health of young people in Scotland. Available at <[https://www.samh.org.uk/documents/Going\\_to\\_Be\\_All\\_Right\\_Jacki\\_Gordon\\_Report\\_2017.pdf](https://www.samh.org.uk/documents/Going_to_Be_All_Right_Jacki_Gordon_Report_2017.pdf)>

<sup>22</sup> Strathclyde University (2016) What do you mean, I have a right to health? Participatory action research on health and human rights

<sup>23</sup> EHRC (2016) Is Scotland Fairer: The state of equality and human rights 2015. Available at <<https://www.equalityhumanrights.com/en/publication-download/scotland-fairer-2015>>

<sup>24</sup> Engender (2018) Our Bodies, Our Rights: Identifying and removing barriers to disabled women's reproductive rights in Scotland. Available at <<https://www.engender.org.uk/files/our-bodies,-our-rights-identifying-and-removing-barriers-to-disabled-womens-reproductive-rights-in-scotland.pdf>>

<sup>25</sup> Purcell et al (2014) Access to and experience of later abortion: accounts from women in Scotland

## 5. Do you have any views on potential impacts of continuing the current arrangements for early medical abortion at home (put in place due to COVID-19) on socio-economic equality?

**Yes.**

Socio economic status should not impact on the ability to access any reproductive health care, including abortion. This includes the impact of hidden costs to accessing services.

Women already experience economic disadvantage as compared with men – the gender pay gap remains 13.3%<sup>26</sup> and women are reliant on social security for a greater proportion of their incomes than men.<sup>27</sup> Women's experience of the labour market and of independent access to and control over financial resources are profoundly gendered – women's provision of unpaid care and childcare in particular results in many women having to move into part-time work which is overwhelmingly concentrated in undervalued, low-paid jobs such as administration, retail and care because of a lack of quality flexible roles. For women on zero-hours contracts or whose employment is precarious may make it more difficult to get time off work for appointments and to pass the pregnancy in the days subsequent to the appointment. Because self-management allows women to undertake their abortion at the most convenient time, the most effective use of the pills is less likely to interfere with work or childcare than working to availability of an in-person appointment.

Costs of travel may include the cost of travel to in-person appointments. Women in Scotland who live in the most deprived areas are twice as likely to access abortion services and are disproportionately likely to access services later in pregnancy. However, this trend is reversed in the island where the most deprived women are the least likely among local residents to access abortion services. This is almost certainly related to the costs and logistics of travelling.

Women's greater responsibility for the care of children is likely as a barrier to attending in-person appointments – Scotland's childcare costs are among the highest in the UK, which are among the highest in the world. For lone parents, the vast majority of whom are women, childcare is likely to be a significant barrier, especially when required to act with some urgency to secure in-person care. Mothers who are forced to ask friends or relatives to provide informal childcare may feel that their privacy is jeopardised or that they have to bring children to appointments with them. Clearly telemedical alternatives would reduce the expense of abortion care, but would also ensure that women on lower incomes do not have other rights restricted.

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<sup>26</sup> Close the Gap (2020) Gender Pay Gap Statistics. Available at < <https://www.closesthegap.org.uk/content/resources/Working-Paper-21-Gender-Pay-Gap-statistics-2019.pdf>>

<sup>27</sup> Engender (2016) Securing Women's Futures. Available at < <https://www.engender.org.uk/content/securing-womens-futures-report/>>

Women who experience domestic abuse may experience financial abuse or controlling behaviour which restricts their autonomy over income. Women who do not have access to an independent income who may not wish their partner to find out that they are having an abortion may face resulting cost barriers in traveling to appointments.

We also note that continuing a pregnancy and raising a child have significant social and economic opportunity costs for women.<sup>28</sup> If women do not wish to be pregnant but the cost of accessing abortion act as a barrier that prevents them from ending a pregnancy, the lifelong economic costs may actively maintain her poverty.

## **6. Do you have any views on potential impacts of continuing the current arrangements for early medical abortion at home (put in place due to COVID-19) on women living in rural or island communities?**

**Yes.**

Women living in remote and rural areas may have to travel longer distances in order to attend an in-person appointment. For some women, this may require overnight stays. Prior to the introduction of telemedicine, women in Shetland and Western Isles NHS Boards had to travel to another health board to access care at any gestation given a lack of local abortion services within their board area. Women are also more likely than men to rely on public transport, which increases practical considerations. It may cost more to travel, particularly if women are relying on ferries or public transport which may be at inconvenient times. Women who live in smaller or more close-knit communities may be less able to travel to appointments discreetly due to longer periods away from home.

Because of the common side-effects associated with after consumption of mifepristone, women may experience nausea, vomiting, or light bleeding. If it is required for women to take this pill in a clinic or hospital, they may be forced to travel a sizeable distance home while experiencing these side-effects in significant discomfort, or have to pay to stay overnight. The obligation to travel distances may also have emotional challenges, such as disclosing information to more people than desired, including employers, and related anxiety over workplace rights.

When the CEDAW Committee heard the complaint against Northern Ireland's abortion laws in 2018, it noted that the economic and social costs of travel are enormous and have particular consequences for women experiencing domestic abuse, with work and childcare commitments, and those in situations of poverty.<sup>29</sup> While the legal situations

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<sup>28</sup> Chiquero, A. N. (2014) The Labour Force Effects of Unplanned Childbearing. Available at <[https://econpapers.repec.org/article/eeelabeco/v\\_3a29\\_3ay\\_3a2014\\_3ai\\_3ac\\_3ap\\_3a91-101.htm](https://econpapers.repec.org/article/eeelabeco/v_3a29_3ay_3a2014_3ai_3ac_3ap_3a91-101.htm)>

<sup>29</sup> Report of the inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women. Available at

are different, the principle that women should be able to access healthcare without emotional, physical and financial barriers, especially those that only exist for a proportion of the population based on their location within a single legal context. Telemedical abortion services will enable women for whom it is safe to manage their own abortion without facing these additional concerns.

**7. How should early medical abortion be provided in future, when COVID-19 is no longer a significant risk? [select one of the options below]**

**Current arrangements (put in place due to COVID-19) should continue.**

**FOR FURTHER INFORMATION**

Contact: Eilidh Dickson, Policy and Parliamentary Manager, Engender

Email: [eilidh.dickson@engender.org.uk](mailto:eilidh.dickson@engender.org.uk)

**ABOUT US**

Engender is a policy and advocacy organisation working on feminist agendas in Scotland and Europe, to increase women's power and influence and to make visible the impact of sexism on women, men and society. We provide support to individuals, organisations and institutions who seek to achieve gender equality and justice.