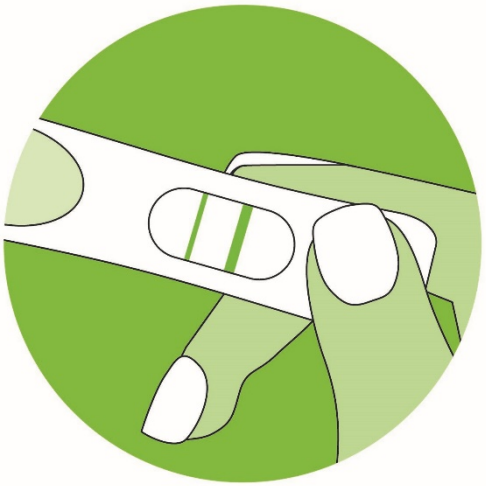
GUIDE TO FILLING OUT THE SCOTTISH GOVERNMENT CONSULTATION ON EARLY MEDICAL ABORTION AT HOME



The Scottish Government is currently consulting on whether it should make permanent changes to abortion services that were brought in at the start of the coronavirus pandemic. These changes allow women to take both pills needed to carry out a medical abortion without needing to travel to a clinic or hospital for an in-person appointment.

We 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 fundamental to women's economic and social rights, to women's autonomy, employment, education and access to resources, and therefore to women's equality.

We believe that abortion should be regulated in the same way as any other healthcare. Abortion services in Scotland continue to place a number of barriers to quality care in women's way, 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. Abortion remains highly stigmatised and subject to legal and service restrictions.

We are asking people who believe in a woman's right to choose to response to the Scottish Government's consultation before the 5th January 2020. **You can do this here.** Without your support in this consultation, Scottish women may lose access to telemedical abortion care.

This response template has been created by ENGENDER

With support from:

BPAS British Pregnancy Advisory Service

AMNESTY INTERNATIONAL

BACKGROUND

Abortion provision in Scotland is still governed by the Abortion Act 1967. As a result of this law, prior to the pandemic, all abortion clients were required to travel to a hospital or specialised clinic to attend an appointment in person. As a result of the restrictions on where abortions could legally be provided, there are generally no more than a handful of clinics in each Health Board that provide these services. In Shetland and Na h-Eileanan Siar, there were no local services at all.

Until the end of March 2020, women who wanted to have a medical abortion, which consists of taking two medications – mifepristone and misoprostol – 24-48 hours apart, have been able to take the second pill at home since 2017, when Early Medical Abortion at Home was introduced in Scotland. Early Medical Abortion accounts for around 80% of abortions every year in Scotland.

Because of Covid-19, the Scottish Government has enabled women in the first 12 weeks of pregnancy to have a telemedical appointment by phone or video call before being sent both pills to take at home along with clear instructions, access to an advice line and pain management. Women who are unsure of their gestation date, who would prefer to be seen in person or who have other health concerns are still able to be seen in person. This change is currently temporary and will be in place as long as the Coronavirus pandemic remains a risk.

Telemedicine provides women with safe, effective and accessible abortion care and increases the choice available for women. Since 2003, the World Health Organisation has been recommending that abortion care be provided at the 'lowest' appropriate level of the healthcare system. It is a common and safe procedure that one in three women will utilise in her lifetime.

We strongly believe that telemedical abortion services should continue after the pandemic and that we should not roll-back the delivery of abortion care in Scotland by denying women an option that has been proven to meet their needs.

HOW YOU CAN HELP

Without your support in this consultation, Scottish women may lose access to telemedical abortion care. We are asking people who believe in a woman's right to choose to response to the Scottish Government's consultation before the 5th January 2020. You can do this here.

We have replicated the consultation questions in this template and included some suggestions for issues you might want to raise in your own answers based on Engender's own response. The consultation consists of the seven questions and you do not have to answer all of them. You can also indicate that you want your response to remain anonymous.

The main points to keep in mind are:

- The current arrangements should be retained permanently. The service is safe, effective, and accessible – and enabling women in Scotland to make the right choice for them regardless of geographic, economic, or social constraints.
- This change in law does not require a certain care pathway or type of treatment, but it enables women and their doctors and nurses to make the right decision for them
- The law shouldn't prevent abortion services from providing the best quality of care they can
- Women's choice should sit at the centre of abortion regulation – enabling them to access the medical care they want and need
- Removing the option to access fully telemedical services would amount to a reduction in the quality of healthcare women in Scotland can access
- Abortion is the most common gynaecological procedure in the world, and 1 in 3 women will access it at some point in their lives.

If you don't have time to add details to your answer, or to answer every question, please still answer Question 1 (Positive Impact), Question 2 (Positive Impact), and Question 7 (option A) to say that the current arrangements should be retained permanently.

QUESTION 1: THE IMPACT OF ABORTION AT HOME

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?

Answers:

a. (Safety) Positive impact
b. (Accessibility & convenience of services) Positive impact
c. (Waiting times) Positive impact

Main point: The introduction of telemedicine has improved patient care, reduced waiting times, reduced gestation at termination, and enabled women to access care without having to prepare for long appointments far from home.

Other things you might want to think about in your response:

- Traveling to clinics and hospitals may require women to travel long distances, take time off work, and find and pay for childcare.
- Women will not have 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.[1] Appointments in person such as for scans can also be shorter.
- Telemedical abortion allows women to choose the most convenient time to take medication and facilitate the most effective interval between the two medicines.[2]
- The need to attend appointments in person may 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. Evidence from providers in England indicate that women are more likely to disclose abuse when they can discuss it outside a clinic setting.
- Telemedical appointments mean that women can access abortion earlier which reduces any potential risks to their health, as well as increasing the availability of in-person appointments for people who need them.[3]

[1] However, telemedical abortion does not change the requirement for two doctors to certify the pregnancy or the grounds for the abortion.

[2] Because the pre-Covid rules for medical abortion at home require women to take the first pill (mifepristone) in the clinic and the second pill 24-48 hours later women have less choice about when they pass a pregnancy.

QUESTION 2: PEOPLE DELIVERING ABORTION SERVICES

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.)

Answer:
Positive, or Don't Know

Main point: Providers across Great Britain have described telemedicine as 'revolutionary' – enabling services to make abortion care one of the success stories of the pandemic – providing timely, safe, high quality care to women even while other healthcare services have struggled.

Other things you might want to think about in your response:

- Providing treatment via telemedicine has allowed providers to better manage clinics and provide additional time to clients who may have more complex reasons for attending in person.
- Because of reduced waiting times, women are treated earlier in pregnancy – allowing greater access to Early Medical Abortion care and minimising the risk of complications.
- NHS services have reported that telemedicine has enabled them to provide services when staff have been redeployed to deal with Covid – indicating that high quality abortion services can now be provided with fewer staff.
- Telemedicine has been accompanied by self-referral into abortion services in a number of areas where this was not already in place. This means that there is less pressure on sexual health, contraceptive, and GP services which may previously have been required to refer patients into the abortion service.
- Reducing in-person appointments supports safety of providers during the pandemic and the safety of patients who still travel to clinics for in person care due to reduced foot fall.

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[3] 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. NHS evidence from Wales has found similar changes – meaning that no woman has to remain pregnant longer than she wants to be.

QUESTION 3: MITIGATING ANY RISKS

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?

Main Point: Abortion is a low-risk procedure which in all instances is safer than continuing a pregnancy to term. In line with the position of leading medical bodies such as the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives, abortion is best managed as medical care between a woman and her clinical team.

Other things you might want to think about in your response:

- Women's needs and wishes should be at the heart of reproductive healthcare.
- There is no law requiring women to have a scan before an abortion and clinical guidelines are clear that routine scanning in every single case is unnecessary.
- Clinical risk should be managed by guidelines and regulation, not legislation. The Scottish Abortion Care Providers are considering how all the learning from the delivery of telemedical services can be incorporated into the future provision of care.
- The existing system of telemedicine, with in-person care where necessary, provides the best options for women who are victim-survivors of sexual violence or domestic abuse, particularly those for whom leaving home for the length of time needed to attend appointment would be unsafe.
- BPAS report that women who access their services are routinely asked whether they feel safe at home and domestic abuse is regularly disclosed to staff. Some women may feel more comfortable disclosing abuse from their own home.
- Legal requirements that do not enable providers to tailor care to individual women's needs and circumstances can mean that some women would not be able to access safe, legal abortion care.

QUESTION 4: IMPACT ON PEOPLE WITH PROTECTED CHARACTERISTICS

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 equalities groups?

Answer:
Yes

Main point: Everyone should be able to access safe, free abortion but currently that doesn't happen. Disabled women, LGBT people and care-experienced women in Scotland report discrimination in accessing reproductive health services, and the costs of travel and childcare are barriers to abortion which have a greater impact on women facing multiple discriminations.

Other things you might want to think about in your response:

- Telemedicine enables providers to tailor care to individual women and their needs. Some women are disproportionately likely to encounter difficulties in accessing in-person care if required – including mothers, victim-survivors of sexual violence, women experiencing domestic abuse, teenage women and girls, women from deprived areas, LGBTI people, disabled women, BME and migrant women, homeless women, women with mental health or substance use issues, and women with insecure immigration status.
- Disabled women, LGBT people and care-experienced women in Scotland report discrimination in accessing reproductive health services.
- Disabled women may 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 premises.
- The cost of travel to clinics or loss of pay for taking time off to attend in-person appointments may affect particular groups disproportionately.
- Abortion stigma is a problem for all women, but women from some religious or cultural backgrounds this may be particularly acute. This is likely to be worsened where women may have to walk past anti-abortion protesters.
- Young women and girls may find it more difficult to travel to in person appointments due to costs, work or education.

- 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.
- Women who are victim-survivors of men's violence may find it easier to access telemedical services with increased privacy and the ability to better control the timing of their abortion.

QUESTION 5: SOCIO-ECONOMIC EQUALITY

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?

Answer:
Yes

Main point: Your socio-economic status shouldn't impact on your ability to access reproductive healthcare. There are hidden costs to accessing abortion services, some of which are removed by early medical abortion at home.

Other things you might want to think about in your response:

- Women in Scotland who are most deprived are more than twice as likely to need to access abortion services as women who are least deprived, and are disproportionately likely to access services later -on in pregnancy.
- This is different in the Islands (Orkney, Shetland, Western Isles) 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 difficulties of travelling to the mainland to access abortion services.
- Women are more likely than men to rely on public transport, which may affect the cost and difficulty of traveling to an in-person appointment – particularly in more rural and remote areas.
- The high cost of childcare versus the cost and difficulties of a woman bringing her children with her for an appointment.
- 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 cost barriers in traveling to appointments.

- Women are more likely to be employed in precarious jobs or zero-hours contracts, which may make it more difficult to get time off work for appointments and to pass the pregnancy in the days subsequent to the appointment.

QUESTION 6: RURAL COMMUNITIES

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?

Answer:
Yes

Main point: Geography shouldn't have an impact on women's ability to access reproductive healthcare and abortion services. Early medical abortion at home removes some of the barriers which face women living in rural or island communities.

Other things you might want to think about in your response:

- Women who live in rural or island communities may have to travel even further to access in person appointments, possibly requiring overnight stays. Prior to the introduction of telemedicine, women in Shetland and Western Isles NHS Boards had no choice but to travel to the mainland to access care.
- 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.
- It may cost more to travel, particularly if women are relying on ferries or public transport which take longer and are at inconvenient times.
- In smaller communities accessing sensitive medical care confidentially can be difficult – this can delay or prevent access to care locally.
- Side-effects 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.

QUESTION 7: THE FUTURE OF EARLY MEDICAL ABORTION

How should early medical abortion be provided in future, when COVID-19 is no longer a significant risk?

Answer: a) Current arrangements (put in place due to COVID-19) should continue – in other words allowing women to proceed without an in person appointment and take mifepristone at home, where this is clinically appropriate.

THIS IS THE MOST IMPORTANT QUESTION IN THE CONSULTATION – PLEASE ANSWER.

FILL OUT THE CONSULTATION HERE

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