Department of Health & Social Care
Open consultation: Home use of both pills for early medical abortion up to 10 weeks gestation

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?

a) Yes, it has had a positive impact

b) Yes, it has had a negative impact

c) It has not had an impact

d) I don't know

[If necessary, please provide text to support your answer]

The primary consideration in any changes to abortion law should be the safety and welfare of women seeking abortion services. The government should ensure all people from all backgrounds and communities can access safe, timely, non-judgmental healthcare including abortion care and sexual health counselling and treatment.

The Royal College of Obstetricians and Gynaecologists and the Faculty of Sexual and Reproductive Healthcare have found that the risks of early medical abortions at home compared to attending a hospital or approved setting are negligible. The risks are likely outweighed by the benefits of earlier, and therefore safer, abortions, in addition to more accessibility and patient choice as to the location of treatment.

As Dr Edward Morris, President of the Royal College of Obstetricians and Gynaecologists, says:

"The statistics…show that while many healthcare services have paused during the pandemic, access to abortion has been not only maintained but improved through the innovative use of telemedicine. This has reduced unnecessary visits to clinics and increased the safety of abortion care. It has also protected both women and their families, as well as healthcare professionals, from possible coronavirus infection and transmission. The data demonstrates why the temporary use of telemedicine for early medical abortion must be made permanent."

The risk of having to attend an approved setting for an abortion is especially high for women and girls from religious communities which are disapproving of abortion. Frequently, their doctor and their pharmacist may also be from the same community which presents a potential barrier to care because some women would be fearful of approaching such a healthcare professional for fear of breach of confidentiality. Younger women, girls and those without independent means may not have the resources or information to travel further afield to seek appropriate care.

The main potential benefit of remote consultations to facilitate treatment for some vulnerable people is that they can consult from their own home without having to explain where they are going or having to consult a doctor or pharmacist from their local community.

An additional benefit of remote access for all women seeking abortions is that it mitigates the risk of having to run the humiliating and daunting gauntlet of anti-choice protestors outside abortion facilities and helps to support confidentiality.

In some cases, face to face consultations are a preferred choice for those seeking abortions, and so these should still be available for people who wish to attend in person or if the healthcare professional conducting the remote consultation feels that it would be safer to do so.

We note that most objections to early medical abortions at home and remote consultations come from those who ideologically oppose abortion under all circumstances, and seek to make it harder for women to access abortion services. Many of these objections are rooted in religious teachings about sex. Religious ideology should not be permitted to determine healthcare policies, especially when accommodating religious beliefs will undermine the health, safety and well-being of patients of all religion and belief backgrounds.

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?

a) Yes, it has had a positive impact

b) Yes, it has had a negative impact

c) It has not had an impact

d) I don't know

[If necessary, please provide text to support your answer]

Please see our answer to the first 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?"

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?

a) Yes, it has had a positive impact

b) Yes, it has had a negative impact

c) It has not had an impact

d) I don't know

[If necessary, please provide text to support your answer]

Please see our answer to the first 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?"

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.

a) Yes, it has had a positive impact

b) Yes, it has had a negative impact

c) It has not had an impact

d) I don't know

[If necessary, please provide text to support your answer]

The temporary measure has allowed healthcare staff to conduct timely, safe, remote consultations. This has mitigated the risk of Covid-19 transmission for both patients and healthcare professionals and has reduced unnecessary travel. The temporary measure has also facilitated an efficient use of limited healthcare personnel, some of whom may have been physically deployed to another area due to the Covid-19 pandemic and who would not otherwise have been able to continue to provide this service.

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?

a) Yes, benefits

b) Yes, disadvantages

c) No

d) I don't know

The risk of having to attend an approved setting for an abortion is especially high for women and girls from religious communities which are disapproving of abortion. Frequently, their doctor and their pharmacist may also be from the same community which presents a potential barrier to care because some women would be fearful of approaching such a healthcare professional for fear of breach of confidentiality. Younger women, girls and those without independent means may not have the resources or information to travel further afield to seek appropriate care.

The main potential benefit of remote consultations to facilitate treatment for some vulnerable people is that they can consult from their own home without having to explain where they are going or having to consult a doctor or pharmacist from their local community.

An additional benefit of remote access for all women seeking abortions is that it mitigates the risk of having to run the humiliating and daunting gauntlet of anti-choice protestors outside abortion facilities and helps to support confidentiality.

In some cases, face to face consultations are a preferred choice for those seeking abortions, and so these should still be available for people who wish to attend in person or if the healthcare professional conducting the remote consultation feels that it would be safer to do so.

Public sector equality duty

As part of the consultation, we're inviting views on the impact of making permanent home use of both pills for EMA on people with protected characteristics and steps that could be taken to mitigate against any adverse impact, against the government's duties under the Equality Act 2010.

Protected characteristics are:

- age
- gender reassignment
- being married or in a civil partnership
- being pregnant or on maternity leave
- disability
- race including colour, nationality, ethnic or national origin
- religion or belief
- sex
- sexual orientation

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?

Making permanent home use of both pills will have a positive impact on all communities, including those defined by the protected characteristics.

The risk of having to attend an approved setting for an abortion is especially high for women and girls from religious communities which are disapproving of abortion. Frequently, their doctor and their pharmacist may also be from the same community which presents a potential barrier to care

because some women would be fearful of approaching such a healthcare professional for fear of breach of confidentiality. Younger women, girls and those without independent means may not have the resources or information to travel further afield to seek appropriate care.

The main potential benefit of remote consultations to facilitate treatment for some vulnerable people is that they can consult from their own home without having to explain where they are going or having to consult a doctor or pharmacist from their local community.

Socioeconomic considerations

In addition to the protected characteristics as discussed above, we're also seeking views on the potential for making permanent home use of both pills for EMA to reduce or increase inequality in health outcomes experienced by different socioeconomic groups.

Question: 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?

Making permanent home use of both pills would reduce the difference in access to abortion for women from more deprived backgrounds or between geographical areas with different levels of disadvantage. Younger women, girls and those without independent means may not have the resources or information to travel further afield to seek appropriate care, so enabling them to use both pills for EMA at home would benefit them in particular.

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

As set out above, the current approval allowing home use of both pills for EMA up to 10 weeks gestation is not permanent. It will currently expire on the day on which the temporary provisions of the Coronavirus Act 2020 expire, or the end of the period of 2 years beginning with the day on which it is made, whichever is earlier. We're seeking views on whether this should be made permanent (noting that, as with any other healthcare service, the measure would be kept under review should new evidence or information emerge), and if not, when the temporary measure should end.

It is important to note that the options for the future of the temporary measure set out in question 10 will be subject to any considerations regarding the COVID-19 pandemic that are relevant at the time the decision is taken.

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

a) Become a permanent measure?

b) End immediately?

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

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

e) Other [please provide details]?

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

This submission is made by the National Secular Society (NSS). The NSS is a not-for-profit non-governmental organisation founded in 1866, funded by its members and by donations. We advocate for separation of religion and state and promote secularism as the best means of creating a society in which people of all religions and none can live together fairly and cohesively. We seek a diverse society where all are free to practise their faith, change it, or to have no faith at all. We uphold the universality of individual human rights, which should never be overridden on the grounds of religion, tradition or culture.

We campaign to protect patients from harm caused by the imposition of other people's religious values. We advocate for a secular approach to current major health issues. We are opposed to religious influences in medicine where these adversely affect the manner in which medical practice is performed. We support patient autonomy and challenge pro-religious discrimination, particularly in those areas of medicine where reasonable personal choice is threatened.

We strongly support the right of women to have legal and safe abortions and access to emergency contraception. We note that most objections to early medical abortions at home and remote consultations come from those who ideologically oppose abortion under all circumstances, and seek to make it harder for women to access abortion services. Many of these objections are rooted in religious teachings about sex. Religious ideology should not be permitted to determine healthcare policies, especially when accommodating religious beliefs will undermine the health, safety and well-being of patients of all religion and belief backgrounds.

Our response has been prepared with the input of our Secular Medical Forum and practitioners with experience in the area of early medical abortions.