Society for the Protection of Unborn Children

TELL THE TRUTH –

SPUC'S campaign to expose the human cost of home abortions

A briefing for supporters

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Introduction

On 30 March 2020, The Secretary of State for Health and Social Care approved **two temporary measures** in England affecting the regulation of abortion during the Coronavirus public health crisis. (See Appendix 1.) These measures allow women to self-administer medical abortions at home, without meeting with a medical professional in person.

On Monday 6 April, Marie Stopes UK launched a "telemedicine" abortion service, followed a few days later by BPAS' (British Pregnancy Advisory Service) "pills by post". Thus making abortion seem simple, easy and normal.

Changes to abortion provision in the devolved governments in Wales and Scotland were made on 31 March and allow the same provisions as in England.

This briefing is to inform supporters of the impact and dangers of remote or DIY home abortions. We also include campaign points for you to write to your MP.

What is remote abortion?

Remote abortion (also known as home or DIY abortion) is when women are assessed for an abortion via a remote consultation, i.e. by telephone or video call. The drugs used for a chemical abortion are then posted to the woman, who self-administers them and aborts the baby at home.

How is this different to previous home abortions?

Since August 2018, Misoprostol, the second stage of the abortion pill process, has been available outside a medical setting; women could take the pills home to administer themselves. This change took place first in Scotland, then Wales and finally in England in December 2018.

The difference **now** is that **both** doses of the abortion drugs (Mifepristone and Misoprostol) can be taken at home. In addition, the abortion pills can be sent to women without their having to see, or be examined by, a doctor in person.

But isn't this only a temporary measure?

The rhetoric from Government and many MPs is that this is only a temporary measure to lessen the risk of women having to leave the house to attend appointments at abortion clinics during the Coronavirus crisis. Many MPs are holding this view in good faith, believing that this is a minor, and sensible, change during a public health crisis.

However, the abortion lobby have been campaigning for these measures for years, and are unlikely to let go of them once the immediate crisis is over. BPAS has tweeted https://twitter.com/bpas1968/status/1251122018793205760: "The fight for telemedical abortion care during the current time shows how outdated our abortion law truly is. Although we are grateful of the decision made regarding telemedicine, meaning we can now provide our Pills by Post service, it should not have taken a medical pandemic to ensure access and availability of abortion care. The move to telemedical services is one which is in the best interest of women and something we have been pushing for, **this should not be temporary**. The legal requirement for 2 doctors to certify an abortion is also clinically unnecessary. We will continue to campaign for abortion to be decriminalised in Great Britain to protect the provision of abortion services and the women who need to access our care."

This is not a minor change. This is a huge change to how abortion is regulated and carried out, and one that poses major risks to women's physical and mental health. It is not acceptable for women's health to be disregarded in this way, even for a temporary period.

Is this change to abortion provision legal?

No. The Abortion Act is a bad law, but it does include certain important limits to abortion. One such limit is that the home is not an approved place for abortion, which offers at least some safeguards for women, if not for her unborn baby: Please see Appendix 2 for more information on the illegality of home abortions.

Are home abortions a simple option for women?

No. The guidance for women from BPAS, Britain's biggest abortion provider, makes it clear that the regimen is quite complicated: https://www.bpas.org/abortion-care/abortion-treatments/the-abortion-pill/remote-treatment/

It involves:

- Taking the first medicine (Mifepristone) with water (which may cause nausea or vomiting).
- One to two days later, placing Misoprostol tablets in the vagina or between the cheek and gum (bucchal administration). The woman must use four tablets first and the remaining two tablets, three to four hours after. There are detailed instructions on how to insert the pills and at what time intervals.
- Monitoring the bleeding with sanitary towels.
- Referring to a long checklist to ensure that the abortion has worked.

BPAS also give multiple instructions for women who might need to seek help.

What is it like to take abortion pills?

The guidance from BPAS makes it clear that taking pills to bring about a chemical abortion is very unpleasant. For example, women are told:

- "You may have nausea or vomiting after swallowing the Mifepristone. If you do vomit you should still use the Misoprostol as outlined in step 2 below"
- "Misoprostol (the second medication) causes strong, painful cramps and heavy bleeding."
- "Some clients describe the taste of Misoprostol as unpleasant and the texture chalky."
- "Placing the tablets between the cheek and gum is associated with higher rates of nausea, vomiting and diarrhoea."
- "Once the pregnancy passes the amount of bleeding and cramping should noticeably reduce. It is likely you will feel cramping on and off for a week or so and this should be easily managed with ibuprofen or paracetamol."

BPAS also lists the risks and complications. (see next page).

Risks and complications of abortion pills

The following information is taken from the BPAS website: https://www.bpas.org/abortion-care/abortion-treatments/the-abortion-pill/remote-treatment/

Significant, unavoidable or frequently occurring risks

These are usually easy to treat and rarely have any long-term health effects.

- Unpredictable time to complete the procedure (variable).
- Side effects of drugs such as nausea, vomiting, diarrhoea, headache, dizziness, fever/chills (common).
- Retained products of conception – where the pregnancy is no longer growing, but some of the pregnancy tissue is left behind in the womb (2 in 100 ≤ 9 weeks. 3 in 100 between 9-10 weeks' gestation).
- Infection (2 in 1,000).
- Unpredictable, irregular or prolonged bleeding after the abortion (variable).
- Pain during the procedure (common).

These may require transfer to hospital or surgical procedures and may have serious long-term health effects.

- Continuing pregnancy (less than up to 1 in 100, up to 3 in 100 between 9 and 10 weeks gestation).
- Haemorrhage – very heavy bleeding (2 in 1,000).
- Undiagnosed ectopic pregnancy (1 in 7,000).
- Death (1 in 100,000).
- Psychological problems (variable).

Extra procedures that may be necessary

- Surgical abortion or uterine aspiration (3 in 100 up to 9 weeks). Between 9 and 10 weeks' gestation 7 in 100).
- Blood transfusion.
- Laparoscopy or laparotomy – operation to look inside the abdomen.
- Hysterectomy – surgical removal of the womb (2 in 100,000).

Danger of death. Death is included in the BPAS list above (1 in 100,000). One researcher found a death rate of 0.009% from medical abortion[1]. Applied to the abortion data from England and Wales, the number of deaths each year from medical abortion might be expected to be around 11 per year.

[1] Niinimaki M et al. (2009) *Immediate complications after medical compared with surgical termination of pregnancy.* Obstet Gynecol 114:795-804

Are there physical risks in allowing women to take abortion pills at home?

Yes. Carrying out an abortion at home is not straightforward and there are specific dangers for women, including:

- **Taking the abortion pills at the "wrong gestation".** Abortion pills are designed to be taken up to ten weeks of pregnancy, as they are less effective, and more harmful for the woman, when taken later in gestation. Many pregnant women do not know their gestation until they have a dating scan. When women guess, they tend to *underestimate* their gestation. Usually the last menstrual period (LMP) is used to estimate gestational age, but LMP alone is not the best obstetric estimate because it assumes a 'regular' menstrual cycle.[2] Studies report that approximately one half of women do not accurately recall their LMP. The consequences for women misjudging their pregnancy dates could be severe. In one UK study more than 50 per cent of women having abortions after 13 weeks (so only a few weeks difference) needed subsequent surgical intervention.[3] There is also no way to ensure the woman does not delay taking the drugs.
- **Not adhering to the precise time intervals between the two stages of the abortion.** The timing between taking Mifepristone (the first pill) and taking Misoprostol (the second dose) is critically important in the effectiveness of the regimen and directly affects how likely the woman is to experience a failed drug-induced abortion and require surgery. Misoprostol is recommended to be taken 24 to 48 hours after taking Mifepristone, otherwise its effectiveness is lowered.[4] Guidance from BPAS and Marie Stopes UK does give precise instructions on the timings, but there is nothing to stop a woman taking the second stage of drugs outside the recommended hours if she is not under medical supervision. Research has shown that, unsurprisingly, women prefer a short time frame between the pills,[5] and so may be inclined to take the second dose less than 24 hours after the first. But this leads to a significant increase in complications with one study finding that nearly one out of every three to four women who took buccal Misoprostol shortly after the Mifepristone failed to abort.[6] (While SPUC would not consider the continued life of a baby to be a "failure", a woman still intending to end a pregnancy would then undergo a surgical abortion in a medical setting – negating any "benefit" of a home abortion).
- **Generally taking the drugs incorrectly.** Non-adherence to the recommended protocol for use of a drug is high, as much as 50% for secondary non-adherence.[7] That is, as much as half of all recommended protocols for prescription drug use are not followed, or not followed correctly. For Mifepristone/Misoprostol this is a particular problem, because more than for most medications, its recommended protocol is fairly precise, and departure from it will increase the rate of incomplete abortion, with its attendant harm to women.

[2] https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/05/methods-for-estimating-the-due-date

[3] "For medical abortion after 13 weeks of gestation, surgical evacuation may be required either at the time for retained placenta or later for persistent retained products of conception. Quoted rates for surgical intervention vary widely between studies and across different regimens, from 2.5% in one study up to 53% in a UK multicentre study. https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf

[4] https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf

[5] https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2014/03/medical-management-of-first-trimester-abortion

[6] https://www.ncbi.nlm.nih.gov/pubmed/17707719

[7] Secondary non-adherence relates to failure to use, or incorrect use of a drug once acquired, whereas primary non-adherence refers to failure to fill a doctor's prescription at all. Hovstadius B & Petersson G (2011) Non-adherence to drug therapy and drug acquisition costs in a national population – a patient-based register study. *BMC Health Services Research 11:326.*

What are the psychological risks of home abortion?

- **The trauma of disposing of the unborn baby.** The BPAS guidance says: "You can decide how you wish to dispose of the pregnancy remains. They can be flushed down the lavatory or wrapped in tissue, placed in a small plastic bag and put in the dustbin."

- **The psychological impact of passing a recognisable baby at home.** A woman may be alone when she aborts and may also see the baby who is expelled.

  This is how one woman described her feelings:

> "It was very hard when a big lump came out when I was in the shower. I had not understood that it would be so obvious when the embryo came, had a shock. Felt like pushing. Did not know what to do with the lump, would have wanted information before about how it can be and what to do with the embryo. The pain, you can take, the hard part was to see the embryo."[8]

Are home abortions safe?

Abortion is never safe. Abortion kills unborn babies and puts the physical and mental health of women at risk.

The World Health Organisation states[9]: "Unsafe abortion – defined as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both – results in the deaths of 47 000 women every year and leaves millions temporarily or permanently disabled."

Home abortions involve both a person lacking the necessary skills (the woman) and an environment lacking minimal medical standards (her home or wherever the remote abortion takes place).

In countries where data collection on abortions is better than in the UK, we know that **complications after medical abortion are four times higher than after surgical**[10] – 20 per cent compared with 5 per cent. These complications include haemorrhaging in approximately one out of six women (15.6 per cent) while more than three out of every 50 women (6.7 per cent) had foetal tissue left inside, most of whom required surgery to remove it.

A large Swedish study[11] has suggested that **a shift to home abortions is the reason complications for medical abortion have doubled in six years**. The study, published in BMC Women's Health, concludes: "The rate of complications associated with medical abortions [at less than 12 weeks' gestation] has increased from 4.2% in 2008 to 8.2% in 2015. The cause of this is unknown but it may be associated with a shift from hospital to home medical abortions."

Dr Greg Pike, Research Fellow at Bios Centre, writes: "Simplistic assertions that medical abortions are 'safe' do no justice to the real experiences of women. The question must be asked, 'safe from what?'. Clearly most women who have a medical abortion are not safe from the very common and distressing experiences of pain, bleeding, nausea, chills, fever, vomiting, diarrhea, dizziness and weakness, each of which can be severe. Neither are women safe from having experienced all of this only to find they must then have a surgical procedure to complete the abortion – at rates perhaps between 6% and 10% (figures that are to be considered *common* according to accepted criteria). Neither are women safe from serious adverse events like blood loss requiring transfusion or infection – at rates that could be up to the 1% mark."

[8] Hedqvist M et al. (2016) Women's experiences of having an early medical abortion at home. Sexual & Reproductive Health Care 9:48-54

[9] https://www.who.int/reproductivehealth/topics/unsafe_abortion/hrpwork/en/

[10] https://www.ncbi.nlm.nih.gov/pubmed/19888037

[11] https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-018-0645-6

Other problems with remote abortion

- **Increased abortion coercion for women experiencing domestic abuse.** Domestic abuse is strongly associated with abortion. Intimate partner violence (IPV) is a risk factor for abortion all over the world.[12,13,14,15,16,] A WHO multi-country study found that women with a history of IPV had increased odds of unintended pregnancy and almost three times the risk of abortion.[17] Removing abortion pills from a medical setting increases the opportunity for abusive partners to force women into having abortions.
- **Missing the opportunity to detect domestic abuse.** Studies on domestic abuse have actually suggested that there should be greater efforts to ask women if they are subject to domestic abuse when they present for an abortion.[18] Remote abortion removes the opportunity for a healthcare professional to detect domestic abuse. Women are given no opportunity to discuss pregnancy confidentially with a doctor.
- **False acquisition of abortion drugs.** There is no way to ensure that abortion pills sent through the post are used by the intended recipient.
- **The potential for even greater loss of unborn human lives.** This DIY abortion scheme further erodes this dignity of human life before birth.

URGENT ACTION

THE GOVERNMENT MUST TELL THE TRUTH ABOUT DIY CHEMICAL ABORTIONS

SPUC supporters have already called on the Government to end the 'temporary' Coronavirus measure of DIY abortions.

However, we must now get the Government to tell the truth about dangerous DIY chemical abortions.

Please contact your MP by letter or email and include:

- The **nine key questions** below for your MP to put to the Secretary of State for Health.
- The **three action points** below for the Department of Health and Social Care.

These questions and action points are specifically aimed at getting the Government to tell the public the truth about DIY abortions.

Please ask your MP to put the key questions below to the Secretary of State for Health and to ask for answers.

Please also ask your MP to contact the Department of Health and Social Care with the three action points below and to ask for an assurance that the Department will undertake these actions.

[12] Hedin LW & Janson PO (2000) Domestic violence during pregnancy: the prevalence of physical injuries, substance use, abortions and miscarriages. *Acta Obstetricia et Gynecologica Scandinavica* 79:625-630.

[13] Taft AJ & Watson LF (2007) Termination of pregnancy: associations with partner violence and other factors in a national cohort of young Australian women. *Australian and New Zealand Journal of Public Health* 31(2):135-142.

[14] Coker AL (2007) Does physical intimate partner violence affect sexual health? A systematic review. *Trauma, Violence, and Abuse* 8:149-177.

[15] Fanslow F, Silva M, Whitehead A & Robinson E (2008) Pregnancy outcomes and intimate partner violence in New Zealand. *Australian and New Zealand Journal of Obstetrics and Gynaecology* 48:391-397.

[16] Silverman JG, Decker MR, McCauley HR, Gupta J, Miller E, Raj A & Goldberg AB (2010) Male perpetration of intimate partner violence and involvement in abortions and abortion-related conflict. *American Journal of Public Health* 100 (8):1415-1417.

[17] Pallitto CC, García-Moreno C, Jansen HAFM, Heise L, Ellsberg M & Watts C (2013) Intimate partner violence, abortion, and unintended pregnancy: results from the WHO Multi-country Study on Women's Health and Domestic Violence. *Int J Gynaecology Obstetrics* 120:3-9.

[18] https://obgyn.onlinelibrary.wiley.com/doi/pdf/10.1576/toag.11.3.163.27500 p 166

Key questions for your MP to put to the Secretary of State for Health

You may like to include additional information on each of the questions for your MP. You can click on the text in red after each question to take you back to the relevant section in the briefing.

1. How will abortion providers or registered medical practitioners operating remotely be certain that a pregnancy is under nine weeks and six days? **Taking the abortion pills at the wrong gestation.**

2. How will abortion providers ensure that women fully understand the correct procedure for the abortion and the risks they run if they do not follow the precise instructions? **Not adhering to the precise time intervals between the two stages of the abortion.**

3. How will abortion providers ensure that women properly recognise when complications occur and that women have the means to access medical treatment? **BPAS also lists the risks and complications.**

4. How will remote abortion assessment ensure that a woman is not being coerced into having the abortion? **Increased abortion coercion for women experiencing domestic abuse.**

5. How will abortion providers ensure that the abortion drugs are taken by the intended recipient? **False acquisition of abortion drugs.**

6. How will serious medical issues such as ectopic pregnancy be identified via an electronic consultation?
   A shift to home abortions is the reason complications for medical abortion have doubled in six years.

7. How can the Department for Health and Social Care justify exposing women to increased physical and mental health dangers from the remote abortion scheme? **What are thepsychological risks of home abortion?**

8. How can the Department of Health and Social Care justify exposing women to the threat of death from abortion pills? **Danger of death.**

9. How can the Department of Health and Social Care justify a DIY abortion regime which trivialises the very serious matter of killing an unborn baby?

Action needed by the Department of Health and Social Care

Please include the following three points in your letter to your MP asking him/her to raise them with the Department of Health and Social Care.

You can include the points in full or just give the short point (in bold).

Please contact your MP by letter or email and include:

1. **The Department must withdraw this extreme abortion measure immediately and must be held fully accountable for the outcome of this regime.** The Secretary of State for Health must report fully to Parliament and the public on this new abortion measure once social distancing is lifted.

2. **The Department of Health and Social Care must call to task abortion providers and medical practitioners certifying for abortion to insist that the NHS number of women undergoing abortion in England and Wales is recorded on the HSA4 abortion form.** This longstanding failure means that there is no accurate way of tracking the health outcomes of women who have abortions. This is even more urgent now that abortion is being so dramatically de-medicalised.

3. **The Care Quality Commission must be mandated to inspect independent abortion providers providing 'pills through the post' and 'telemedicine' abortions at the earliest opportunity.** The CQC has found extremely serious breaches of health and safety at both bpas and Marie Stopes UK. As recently as March of this year, a Parliamentary question disclosed that 59.3% of approved abortion locations required safety improvements.[19] This track record does not bode well for the safety of women under the remote abortion regime.

Please write to your MP protesting against this dangerous home abortion policy.

For supporters in England: Please ask your MP to raise the six key questions with the Secretary of State for Health and also the three urgent points of action for the Department of Health and Social Care.

For supporters in Wales: Please write to your Westminster MP and also to your Assembly Member to raise these important points with the Minister for Health and Social Services.

For Supporters in Scotland: Please write to your Westminster MP and also to your MSP to raise these important points with the Minister for Public Health, Sport and Wellbeing.

Please send your replies to SPUC. This is very important. Thank you.

Appendix 1

The abortion lobby has been campaigning for years to make abortion access even easier, and took advantage of the current public health crisis to promote their ideology and introduce remote or DIY abortion.

The timeline of events was:

- **Monday 23 March 2020:** A letter appears on the Department of Health's website which classed the home of a doctor as a place where abortion could be prescribed and the home of the woman as the place where the abortion could take place. Later that evening the document was removed from the website, with the website stating that the announcement was "published in error, there will be no changes to abortion regulations." Over the next few days, Government spokespeople, including the Health Minister, stated repeatedly that no changes were planned to abortion regulations.
- **Wednesday 25 March:** Amendments to allow home abortions, and to dispense with the requirement that two doctors certify a woman for an abortion, are tabled to the emergency Coronavirus Bill. The Government spokesperson speaks out strongly against these amendments, and they are withdrawn.
- **Monday 30 March:** The Health Minister approves a woman's home as a place where abortion pills can be taken, and a doctor's home as a place they can be prescribed.
- **Tuesday 31 March:** Similar approvals are made by the Health Minister in Wales and the Chief Medical Officer in Scotland
- **Monday 6 April:** Marie Stopes UK launches a "telemedicine" abortion service, followed a few days later by BPAS' (British Pregnancy Advisory Service) "pills by post".

[19] https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2020-02-27/21971/

Appendix 2

Remote abortion contravenes the 1967 Abortion Act in these ways:

1. The taking of Mifepristone and Misoprostol at home without the presence of a medical practitioner, or a nurse or other member of clinical staff ultimately subject to a medical practitioner's direction, is not consistent with section 1 of the 1967 Act.
2. The approval of a pregnant woman's home as a class of place where treatment to terminate pregnancy may take place is so broad as to not properly constitute a permissible class [of place].

There have been two rulings against SPUC holding that the law does allow the home to be designated as an approved place and it is held so by the government and devolved governments.

We believe the 1967 Abortion Act is being misconstrued to permit home abortions. It is difficult for SPUC to assert this in the face of huge opposition from the legal establishment and the Government which has had to perform legal gymnastics which stretch credulity beyond breaking point.

The current measure for remote abortion

On 30 March 2020, "The Secretary of State for Health and Social Care has approved 2 temporary measures in England to limit the transmission of coronavirus (COVID-19) and ensure continued access to early medical abortion services:

- women and girls will be able to take both pills for early medical abortion up to 10 weeks in their own homes, without the need to first attend a hospital or clinic
- registered medical practitioners (doctors) will be able to prescribe both pills for the treatment of early medical abortion up to 10 weeks from their own homes"

"This approval expires 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."

"The treatment must be carried out in the following manner

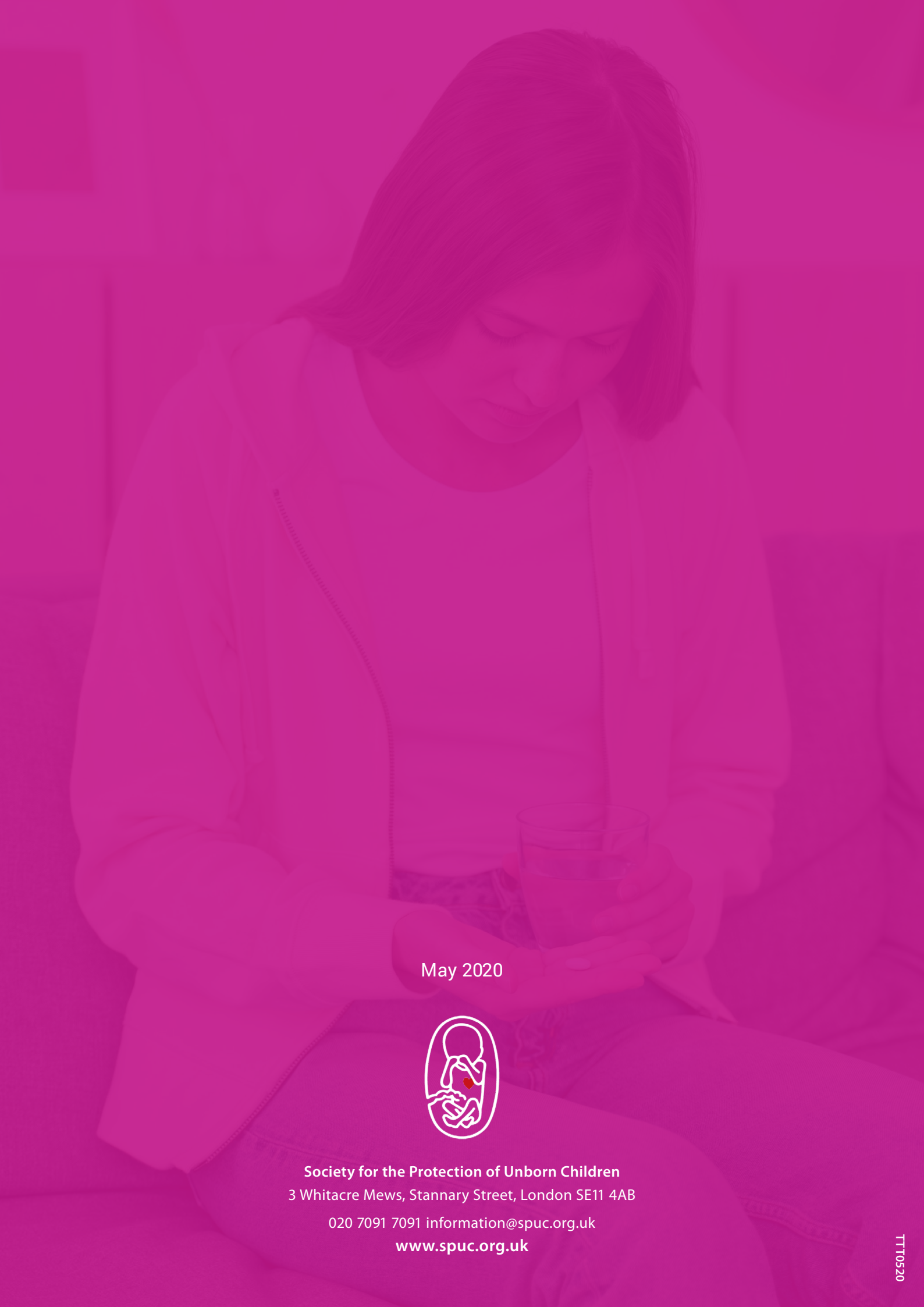
a) the pregnant woman has

i) attended an approved place;

ii) had a consultation with an approved place via video link, telephone conference or other electronic means, or

iii) had a consultation with a registered medical practitioner via video link, telephone conference or other electronic means; and

b) the pregnant woman is prescribed Mifepristone and Misoprostol to be taken for the purposes of the termination of her pregnancy and the gestation of the pregnancy has not exceeded nine weeks and six days at the time the Mifepristone is taken."



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