British Society of Abortion Care Providers

Submission to the

Women and Equalities Committee

Inquiry

Unequal Impact: Coronavirus (COVID-19) and the impact on people with protected characteristics

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Background to the organisation making this submission

The British Society of Abortion Care Providers (BSACP) is the principal, authoritative Society for health professionals working in abortion care in the UK, its Crown Dependencies and its Overseas Territories. It sets out to provide a supportive community to promote best practice in abortion care. It was formed in October 2015 and is a specialist Society of the Royal College of Obstetricians and Gynaecologists (RCOG). It is separate from the RCOG but works closely with it and with the Faculty of Sexual and Reproductive Healthcare (FSRH). Our membership comprises mainly doctors, nurses and midwives who deliver abortion care for the National Health Service (NHS) – whether in NHS settings or the independent sector. The three main independent sector providers (ISPs) are: the British Pregnancy Advisory Service (BPAS), Marie Stopes (MSI) and the National Unplanned Pregnancy Advisory Service (NUPAS).

Introduction

BSACP very much welcomes this Inquiry. We are acutely aware of the particular impact the coronavirus pandemic is having on some people with protected characteristics under the Equality Act 2010; sex and pregnancy & maternity are the two characteristics that we would like to focus on in our submission.

As well as this early submission, BSACP intends to make a further submission in six months' time. Necessarily, our first submission is a general impression after one month of lockdown. We hope to be able to provide more detail, including statistics, in our later submission.

We can confirm that we consulted our membership, asking for examples and overall impressions of the impact of the pandemic. We would point out that most of our members are clinicians working under intense pressure at the present time, coping with illness and staff shortages due to sick leave and self-isolation and the requirement to rapidly develop new ways of delivering abortion care services. Consequently, the returns collected and collated from respondents have been quite brief.

General points

Pandemics make existing gender inequalities for women and girls worse and can impact how they receive treatment and care.[1] The closure of schools has a differential effect on women economically.[2]

BSACP believes that the evolution of the SARS-CoV-2 virus, and the impossibility of its eradication, is going to mean that the UK (and the rest of the world) will never be the same again.[3] History has taught us that sexual and reproductive health (SRH) and rights are often casualties of conflicts and emergencies - this virus is no different as it spreads through the population and the authorities react to it. The profound impact of this crisis[4] is likely to mean that women will have *more* need of reproductive healthcare, including decisions about preventing pregnancy, continuing a pregnancy affected by factors such as exposure to COVID-19, loss of income and many other health concerns brought on by the pandemic.[5] Although lower resource countries are likely to experience proportionately more impact, the impact in the UK on sexual and reproductive health (SRH) is likely to be profound unless immediate ameliorating measures are taken. It has been estimated that globally, assuming health service disruptions are medium (rather than high or low), a 6-month lockdown would result in 4 million additional unintended pregnancies.[6]

UK contingency plans have been inadequate to deal with the unprecedented nature of this pandemic. The response by government has been to funnel nearly all effort into acute services, with no compensatory mitigating measures. Many NHS staff have been redeployed to work in front line acute service settings. Specialist SRH services have mostly been reduced to telephone advice only and general practice services are similarly almost exclusively done remotely with consequent restrictions to contraceptive supply, choices and care. Many services have to be booked online; this disadvantages those who do not have access to the internet or have difficulty navigating the internet and may previously have relied on walk-in arrangements. Long-acting reversible contraception (LARC), such as implants and intrauterine devices, has largely ceased to be accessible to new users, with advice being given out to existing users on how their lifespan of devices currently in use can be extended.[7] This clearly does not help those who want to initiate a LARC method or those who are having problems with side effects. Copper IUD insertion as a form of emergency contraception is largely unavailable. Sterilisation procedures are not taking place. The knock-on effect of this will inevitably be an increase in conceptions.

The incidence of domestic violence and rape - and likely sexually transmitted infections (STIs) too - increases while access to services become almost non-existent. Rape and domestic violence increase the need for emergency contraception, abortion and contraception in the first instance. As always, the impact on marginalised individuals and communities is proportionately greater.

Effect on abortion services

Around a quarter of abortion clinics in the UK were closed towards the end of March due to coronavirus-related staffing issues.[8] In the first week after lockdown, one ISP has reported that 20 of its clinics were closed and 1,120 appointments had had to be cancelled.[9] Reduced availability of operating theatre time has massively decreased the availability of surgical abortion to women.[a] However, as well as this, our members report that there are more women than usual failing to attend their appointments for surgical abortion in some services; some of this may be due to long waiting times with women finding alternatives such as another healthcare provider with an earlier appointment or using web-based providers and failing to cancel the previous appointment. Most women are opting for medical abortion, partly because of these service reductions, partly because of improved accessibility of early medical abortion in the last few weeks and partly because of travel restrictions and social distancing. One of the ISPs reports that currently 97% of its treatments are being done remotely. Another ISP has seen an increase in numbers of women seeking abortion, but it is unclear whether this represents increased demand or, perhaps more likely, a backlog created from women being too frightened to present for healthcare earlier on in the pandemic. In general, our members report that numbers of early medical abortions are significantly increased, with orders for the necessary medicines having to be augmented. Currently, fewer higher gestation cases are being seen by both NHS and independent sector services and it is unclear why this is the case.

Abortion regulations

Taking a longer term view, BSACP does not believe that abortion should be exceptionalised with specific certification.[10] For the purposes of reducing barriers to access during the pandemic, BSACP is in favour of reducing the number of doctors required to certify an abortion from two to one.[b] This can be done by the Secretary of State for Health and Social Care in England, and counterparts in Wales and Scotland, by powers vested in them by the Abortion Act 1967. (Northern Ireland now has a more liberal law in this respect with only one health professional needing to sign at gestations up to 12 weeks).

In England, Wales and Scotland regulations have been modified so that remote (by video or telephone) consultations[11] and taking both abortifacient drugs (i.e. mifepristone and misoprostol)

[a] Within this submission we use the term woman. However, it is important to acknowledge that it is not only people who identify as women for whom it is necessary to access women's health and reproductive services in order to maintain their health and wellbeing. Abortion services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

[b] This would be in similar vein to waiving the second signature for 'sectioning' under the Mental Health Act and for cremations which is contained in the Coronavirus Act 2020

for medical abortion at home is now allowed. In addition, based on medical evidence including that from the National Institute for Health and Care Excellence (NICE),[12] recommendations from professional bodies have been followed; consultations have been simplified by reducing routine measurements and investigations and by omitting ultrasound scanning where possible (so-called 'no touch' procedures).[13] We would like to see similar modifications made in Northern Ireland where, although there is now a more liberal law in place in some respects (single signature), regulations still do not allow taking both drugs for medical abortion at home and nor are there (yet) *any* commissioned services providing care from within the nation.

Remote consultations are beneficial for those who would otherwise need childcare to attend an appointment. However, they may pose a problem for those whose first language is not English and restrictions on the use of professional interpreters for face-to-face consultations are challenging.

Regarding upper gestational limits for medical abortion at home, most clinicians are hidebound by a limit of 9 weeks and 6 days for remote medical abortion; it is only in Scotland that the gestation is open (but generally advised in clinical guidance to extend only to 11 weeks and 6 days). It means that women at 10 - 12 weeks' gestation in England and Wales are forced to attend a health facility, whereas in many cases they could safely be managed at home.[13] Providers can discharge the woman immediately after administering the medication in licensed premises, but that woman then not only has an unnecessary journey but risks having to endure bleeding, pain and even passing the pregnancy during her journey home which is an intensely distressing, and wholly avoidable, complication.[14] BSACP would like to see the legal/regulatory restrictions on gestational age permitted for home use removed so that only clinical and patient safety factors influence the place of administration and the unnecessary risks and distress described above can be avoided.

BSACP feels it is of note that improved accessibility to medical abortion in England, Wales and Scotland has come about not because of proactive strategic decisions from our authorities, but rather despite the approach of these bodies. Intense pressure for change from the public and experts was required before these safe and simple alterations of regulation were enacted – and sadly Northern Ireland authorities continue to fail to respond to this public health need. Paradoxically, rapid service transformation to enable remote care is one of the success stories of the pandemic era to date. The modified service delivery is more patient-centred than hitherto, better serves vulnerable groups and is in line with best practice outlined by NICE and international guidelines. When the coronavirus regulations are reviewed, we would strongly recommend retaining

the extra flexibility that remote consultations give clinicians and service users, as proposed by European specialist organisations.[15]

Effect on service users

In line with the reaction seen among the general public as a whole, women with unintended pregnancies appear to have been staying away from the health service out of concern about becoming infected. At the present time, it is unclear how much the pandemic is making women change their decisions about childbearing and how much it is merely delaying decision-making. We suspect it is more the latter and are concerned that we might soon see an increase in presentations at higher gestations, with at best just the associated increased risks from higher-gestation abortion, but at worst an inability for services to meet that demand, with some women going beyond the legal limit as a consequence. (NB. Inadequate capacity for higher-gestation abortion is already a problem in some geographical areas and for women with complex medical conditions in particular). Despite generally reassuring evidence about any effect of coronavirus on the developing fetus, many women are anxious about this; it is possible that some are opting for abortion after weighing up all their circumstances when in non-COVID times might not have done so.

BSACP is concerned that choice for service users has become limited. Effects of the pandemic on abortion services means that the availability of surgical options is sparse.

We would like to highlight a numerically small but important group of pregnant women who need particularly intensive, specialist monitoring and care and who were already adversely impacted / unfairly disadvantaged before the pandemic. Again, it is possible that those with complex medical conditions in non-COVID times might have continued their pregnancy knowing that excellent antenatal care would be readily available to them. Antenatal care is now generally disrupted, simplified and not so easy to access. Those with complex conditions who opt for abortion cannot be dealt with by ISPs; accessing abortion may involve travelling to a hospital outside their locality for pre-treatment investigations as well as for treatment. During lockdown this is logistically problematic due to travel and accommodation restrictions and shutdown.

Another group of concern is those women in the second trimester who have made a decision to terminate the pregnancy and who cannot travel to a specialist centre because of childcare, travel or accommodation issues. These women may well end up being forced to continue with an unwanted pregnancy.

Coercive control and gender-based violence

Global estimates are that, for every 3 months the lockdown continues, an additional 15 million cases of gender-based violence will occur.[6] It has already been shown that coercive control has increased in the UK since lockdown. Refuge has reported a surge in online and telephone contacts with the National Domestic Abuse helpline.[16] BSACP is familiar with the phenomenon of reproductive control[17] and with domestic violence – the two overlap and probably have similar antecedents. Forced sex and contraceptive sabotage are two of the behaviours that those with unintended pregnancies who present to our members are describing. The vast majority of cases of coercive control involve men controlling women and our experience is that coercive control is more commonly seen in the form of denying women access to healthcare and abortion than attempting to force her to have an abortion against her will. It would appear that there is a direct correlation between imposition of social distancing measures and threats to women's wellbeing, health and safety in this respect. Remote consultation is essential for these women as, during lockdown, they find it hard to leave their house without having to give a reason.

BSACP members noted that they were concerned that anti-abortion groups often state that safeguarding can only be provided in face-to-face consultations. Providers have protocols in place to ensure that a woman is able to talk in private and is not being coerced. It seems likely that this is easier to achieve where a woman can use her own smartphone in private than when she has to attend a clinic where a coercive partner is aware of, or indeed even present at, her consultation. BSACP believes that some women will feel better able to talk freely when they are in their own environment than they may when in a clinic environment that might feel intimidating.[c]

Particular groups

One of the groups of concern reported to us by members is that of single parents. There have been cases of pregnant individuals living solely with their children who have clinical reasons that require them to attend for investigations and/or abortion treatment but find they are unable to identify anyone who can provide childcare whilst they make those visits. Providers are then faced with dilemmas about whether to allow children to be brought to the service setting. Whilst children attending a clinic is never seen as desirable, it might previously have been tolerated, whereas in the

[c] As an illustration of how safeguarding via telephone can be effective, one ISP has reported two major safeguarding cases being detected through telephone consultations prior to lockdown. One case involved a human trafficking ring which resulted in several women being rescued; another identified a 12-year old girl being abused by her stepfather and uncle.

coronavirus pandemic this seems unacceptable and yet might seriously compromise the patient's access to care.

Another group of women are younger women of tertiary education age (18 – 25) who have lost the independence of living away from home and have been sent back to live with their parents as universities have closed. Under the scrutiny of their parents, who may be unaware of their daughter's sexual activity, it will be far harder for them to access health facilities.

Supply chain disruptions

Worldwide, massive efforts are taking place to avoid stock-outs of vital supplies. There are stock-out risks of all major contraceptive products in the next 6 months in 46 low-resource countries.[18]

BSACP is aware that even before the pandemic took hold, government decisions had jeopardised the supply of women's medicines in the UK, including contraceptives and hormone replacement therapy (HRT). Supply chains are now even more fragile.

Due to lack of availability of LARC services at present, many more people than usual are using progestogen-only pills. There has been an increased need for supplies of progestogen-only pills and any interruptions in supply would have a disastrous impact. Assuming supplies remain intact and adequate, BSACP believes that it would be beneficial to simplify access to this method of contraception and we support recommendations to change the classification of progestogen-only pills from prescription-only medicines (POM) to pharmacy (P). We understand that this had already been raised with the Medicines and Health Products Regulatory Agency before the pandemic.

In relation to the drugs mifepristone and misoprostol, which are on the World Health Organization (WHO) List of Essential Medicines,[19] we feel that the government must give a high priority to ensuring adequate continuing supplies. At the time of writing, there are already shortages of other critically important drugs, such as anaesthetic and sedative medications (propofol, midazolam and fentanyl), without which the ISPs cannot function. It is therefore essential that the ISPs have priority access to these medicines in order to be able to continue to provide NHS-funded abortion care in the ISP setting, since they cannot use the alternative anaesthetic options available to those working in NHS hospitals.

In relation to Personal Protective Equipment (PPE), although the ISPs deliver essential NHS-funded services, all of them have reported difficulties in accessing PPE via the NHS supply chain, which does not regard them as being part of core health services. This is clearly nonsensical.

Conclusions

We conclude that the coronavirus pandemic has already had a major impact on women of reproductive age and in particular pregnant women. There is currently a gross neglect of the reproductive health needs of women in the UK. Only a highly restricted range of contraceptive options is available due to direct and indirect consequences of the pandemic. The worrying prospect of shortages of progestogen-only pills due to supply chain issues on top of these restrictions is very troubling. Unless urgent measures are taken, we predict a surge of unintended pregnancies in the coming months. Abortion services are running thanks to the dedication and ingenuity of providers but, again, they are not able to offer a full range of services. This comes against the backdrop of providers being prevented from offering woman-centred, best practice owing to the rigid constraints imposed by the criminalisation of abortion in the UK. The ability of abortion services to meet the need of those requesting abortion across the full range of gestations will be apparent in six months' time. The UK government must fulfil its obligations under international human rights law and ensure that sexual and reproductive health services are not attenuated or suspended in times of crisis and that women are not discriminated against.[20]

BSACP position

1. BSACP fully supports the call for governments to adopt an intersectional and gender-sensitive response to the pandemic and include women's perspectives in decision-making.[15] This will ensure that the economic and social response to the crisis addresses the specific situation of women and does not reinforce existing inequalities.
2. BSACP supports the call for abortion to be declared by the government as an essential and time-sensitive service.[21] This will help to ensure the safety, dignity and wellbeing of those who need to use the service.
3. BSACP supports the call for the option of remote care to become integrated as a permanent option in abortion care.
4. BSACP proposes that the certification for abortion is simplified to one signature pending a more comprehensive reform to decriminalisation in the longer term.[10]
5. The government must ensure that contraceptive services get back to a semblance of normal as soon as possible; otherwise there will be a sustained surge in conceptions and unwanted pregnancies.

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