Department of Health and Social Care's open consultation on:
Home use of both pills for early medical abortion up to 10 weeks gestation.

Recommendations from the
Helena Kennedy Centre for International Justice,
Sheffield Hallam University.

By

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Contents

1. Executive Summary 1
2. About the Helena Kennedy Centre for International Justice 2
3. Contributors 2
4. Our Submission 2
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? 2

1. Executive Summary

The Helena Kennedy Centre for International Justice (HKC), Sheffield Hallam University, is pleased to submit a response to the Department of Health and Social Care's open consultation on the home use of both pills for early medical abortion up to 10 weeks gestation.

The HKC is based in the Department for Law and Criminology at Sheffield Hallam University which hosts a number of undergraduate and postgraduate degrees and PhD research programmes including law, criminology, and human rights. Six third-year Law and third-year Law and Criminology students studying an elective module in Rights of Women worked with their tutor, Severyna Magill, to prepare this report.

Some editorial changes have been made to the original submission. These do not affect the submission's core content.

2. About the Helena Kennedy Centre for International Justice

The Helena Kennedy Centre for International Justice is a leading centre for social justice and human rights. It provides a vibrant environment at the cutting edge of legal and criminal justice practice which prepares students for excellence in their chosen professional career. Its central values are those of widening access to justice and education, the promotion of human rights, ethics in legal practice, equality and a respect for human dignity in overcoming social injustice. The centre is home to a range of social justice and human rights activities that include:

- research and scholarship work
- global engagement
- impact on policy
- professional training and advocacy

3. Contributors

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4. Our Submission

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

The current temporary measures implemented in response to the Covid-19 pandemic providing early medical abortion via telemedicine and allowing women to self-administer

both mifepristone and misoprostol medication at home has had a positive impact on women's safety.

The availability of safe and effective medical abortion has changed the landscape of abortion provision since 1992 when medical abortion medicines first started to be used in England. Statistics demonstrate it is a safe procedure with very few reported complications encountered in relation to EMA (early medical abortion). The non-invasive nature, and low risk of complication attached to medical abortion, commonly administered at less than 10 weeks' gestation, has contributed to its significant levels of use.[1] The DHSC reported between January to June 2020, medical abortions accounted for 82% of all abortions that took place in England and Wales. If offered a choice, the majority of service users will opt for EMA considering that it is a less invasive, and a less traumatic experience for the pregnant person, and it does not require anaesthetics or surgery, it can be used at an earlier stage than surgical methods and, the earlier the procedure is carried out, the lower is the risk of complications.[2] Making the current temporary measures permanent will continue to protect the safety of pregnant individuals who want to terminate their pregnancies which are less than 10 weeks.

Continuing the delivery of telemedicine appointments on a permanent basis will have a positive impact on women's safety. It is expected to reduce barriers to accessing service provision whilst allowing women to secure appointments at an earlier stage, removing the need to travel, and reducing financial the costs linked to receiving treatment, etc. All of these factors combine to mean women are more likely to access abortion services earlier and therefore have their abortion sooner, thus reducing the chance of them experiencing complications.

The Equality Impact Assessment for National Sexual Health Policy[3] states services must be provided fairly to all populations regardless of age, gender, ethnicity, language, disability, sexual orientation and religious or personal circumstances. This recognises how access to abortion is directly linked to right to health and 'puts women's health and bodily autonomy at the top of human rights conversations by requiring states to provide safe, legal, and

[1] Department of Health, *Evaluation of Early medical abortion Pilot Sites*, p 6 available https://eprints.soton.ac.uk/185967/1/dh_084617.pdf accessed 21 February 2021.
[2] Idib p 7.
[3] Department of Health, *Equality Impact Assessment for National Sexual Health Policy,* (London, Department of Health, 2010) available http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111227 accessed 21 February 2021.

effective' access to medical abortion.[4] The State has a positive obligation under international treaties and law to ensure 'everyone's right to access key sexual and reproductive health services and information that facilitate individuals' ability to make free and informed choices over their SRH' is realisable.[5] International consensus confirms the significance of a growing set of rights: reproductive rights and the right to health,[6] highlighting the importance of SRH to realise human dignity and equality, elements perceived the 'cornerstones of human rights law'.[7]

Specific measures must therefore be adopted to guarantee women's timely and affordable access to abortion services. This must be based on the 'health needs and human rights of women and a thorough understanding of the service-delivery system and the broader social, cultural, political and economic context'[8].

When addressing the UK's approach towards pregnancy as a protected characteristic included in Equality Act 2010 and other women's reproductive rights ramifications, a close encounter with the Abortion Act 1967 reveals the existence of a "consensus amongst contracting [S]tates that abortion should be available on maternal health grounds". Although the implementation of regulated access to abortion confirms the criminalisation of the action, the main question remains "whether a given set of legal arrangements respects someone's ability to exercise that legally recognised right or to realise that legally recognised interest".[9]

S.1 of the 1967 Act[10] states that all terminations must take place in an NHS hospital or a "class of places" approved by the Secretary of State.[11] The regulation of abortion aimed to reduce the mortality rate associated with unhygienic, unsafe, and unregulated abortions before the Abortion Act was enacted. It is therefore intended to protect the health and safety of women who otherwise terminated their pregnancy without the assistance of a competent health practitioner, or in unsafe locations. However, the statutory limitation of

[4] Centre for Reproductive rights, *UN Human Rights Committee Asserts that Access to Abortion and Prevention of Maternal Mortality are Human Rights* available https://reproductiverights.org/press-room/un-human-rights-committee-asserts-access-abortion-and-prevention-maternal-mortality-are accessed 21 February 2021

[5] UNCESCR, 'General Comment 22', Note 1, paragraph 5.

[6] Bharati Sadasivam, 'The Rights Framework in Reproductive Health Advocacy -- A Reappraisal', [1997] 8 Hastings Women's L.J. 313 available https://repository.uchastings.edu/hwlj/vol8/iss2/4 accessed 21 February 2021.

[7] Claire Lougarre, 'The Protection of Sexual and Reproductive Health in European Human Rights Law: Perspectives from the Council of Europe' (2018) 14(4) CIL 249-276, p 1.

[8] General Recommendation No 24 (20th session 1999)

[9] Rosamund Scott, 'Risks, reasons and rights: the European convention on human rights and English abortion law', Medical Law Review, Vol. 24, No. 1 page 6

[10] Abortion Act 1967, s 1.

[11] Interim Procedures for the Approval on Independent Sector Places for the Termination of Pregnancy, DH, August 2012.

premises where a termination of pregnancy can take place remains widely criticised. Calls have been made to widen the scope of an approved class of place as part of proposed actions to strengthen policies and services related to abortion.[12] Driven perhaps by the desire to eradicate clandestine and highly unsafe abortions, common before the statutory framework was implemented, the language used in the relatively short provision setting the legality of the act enshrines outdated attitudes and fails to encompass the modern technological, medical, scientific etc. evolution encountered in the 21st century.[13]

The use of mifepristone followed by the administration of misoprostol to initiate expulsion of the pregnancy has been a globally- recognised method of termination for some years and extensive data suggests that EMA remains a preferred treatment method.[14] The increase in the proportion of abortions that are performed under 10 weeks in England and Wales (from 75% in 2009, to 82% in 2019)[15] demonstrate the acceptability of the treatment and a shift in the preferred method of abortion for both patients and practitioners. Similarly, EMA facilitates access to treatment of women belonging to a vulnerable or disadvantaged group whose health status remains impacted by other social factors.

Given that medical abortions where not possible in 1967, it can be argued that the current legal framework available plays no useful role in fulfilling the treatment in practice and is restricting access to the non-invasive and safe procedure.[16]

The concept of safety surrounding termination of pregnancy suggested by the drafters of the 1967 Act was countlessly addressed/interpreted by the judiciary. It was established, that in order to comply with the provisions of section 1, 'abortions have to be carried out in conditions that were both safe and hygienic'.[17] Lord Keith's reference to the "safest

[12] Royal College of Obstetricians and Gynaecologists, 'The care of women requesting induced abortion' available https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf accessed 21 February 2021.

[13] Sally Sheldon, 'The decriminalisation of Abortion: argument for Modernisation', (2016) Oxford Journal of Legal Studies, Vol. 36, No. 2

[14] Department of Health and Social Care, *Abortion Statistics,* (England and Wales: 2017), available https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/763174/2017-abortion-statistics-for-england-and-wales-revised.pdf accessed 21 February 2021.

[15] Department of Health and Social Care, *Home use of both pills for early medical abortion up to 10 weeks' gestation*, available https://www.gov.uk/government/consultations/home-use-of-both-pills-for-early-medical-abortion/home-use-of-both-pills-for-early-medical-abortion-up-to-10-weeks-gestation accessed 21 February 2021.

[16] BMA The law and the ethics of abortion, BMA reviews September 2020 available https://www.bma.org.uk/media/3307/bma-view-on-the-law-and-ethics-of-abortion-sept-2020.pdf accessed 20 February 2021.

[17] In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland) Reference by the Court of Appeal in Northern Ireland pursuant to Paragraph 33

conditions attainable" being required for abortions confirms the statutory emphasis on women's health and safety. However, the introduction of a restriction of approved places was intended to further safety, and failed to predict the replacement of surgical abortions with pharmaceutical abortions. Thus, the continuation of allowing medical EMAs to continue in pregnant people's homes, in cases where there are no known risks, will not jeopardise women's safety.

It was recognised *Tysiac v Poland* that 'once the legislature decides to allow abortion, it must not structure its legal framework in a way which would limit real possibilities to obtain it'. [18] "These restrictions thus appear redundant in terms of safeguarding women's health and, moreover, their rigid enforcement risks impeding the efficient delivery of services so as to delay timely access to abortion. Given the greater risks involved in later terminations, this creates a clear potential for these provisions to increase the dangers to women seeking abortion services."[19] Furthermore, the operation of the law may threaten the safety of abortions. This may result in delayed access to termination, coupled with the increased maternal risks of second trimester surgical abortion, reliance on unapproved abortifacients etc. resulting in increased cost implications surrounding unsafe abortions.[20] International bodies such as WHO confirm that the costs of adding safe abortion care to existing health services are likely to be low, 'relative to the costs to the health system of treating complications of unsafe abortion'.[21]

International human rights treaties, which the UK is party to, introduced the right to the highest attainable standard of health back in 1966.[22] The International Covenant of Economic, Social and Cultural Rights instructs states to 'determine the adequacy of health systems by relying primarily on the cornerstone's principles of human dignity and non-discrimination, and then on external expertise'.[23] In the attempt to ensure safe access to health services, the State recognises an important role for doctors as gatekeepers to abortion services[24], whilst acknowledging the existence of other factors to be taken into

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of Schedule 10 to the Northern Ireland Act 1998 (Abortion) (Northern Ireland), *[2018] UKSC 27.*

[18] ECHR 2007-5410 para 117.

[19] Idib 9, p 346.

[20] Department of Health, *Guidance in Relation to Requirements of the Abortion Act 1967*, (Guidance, 2014); Vlassoff M et al., 'Economic impact of unsafe abortion-related morbidity and mortality: evidence and estimation challenges', [2008] Brighton, Institute of Development Studies, (IDS Research Reports 59).

[21] World Health Organisation, *Safe Abortion: Technical and Policy Guidance for Health Systems*, (Geneva, 2nd edition,2012).

[22] International Covenant for Economic, Social, and Cultural Rights (ICESCR) Art. 12. The UK became a state party in 1976. UN Office of the High Commissioner for Human Rights, (2021). Status of Ratification Interactive Dashboard. Retrieved from https://indicators.ohchr.org/.

[23] *Claire Lougarre, 'Clarifying the Right to Health through Supranational Monitoring: The Highest Standard of Health Attainable', [2015] Public Health Ethics.*

[24] *Sally Sheldon, Beyond Control: Medical Power and Abortion Law (London, Pluto 1997).*

account including the wellbeing of the woman, her privacy and the avoidance of commercial exploitation. Women requesting the self- administration of the EMA treatment at home must comply with the statutory hurdle. These impediments overlook that many patients self-administer medication for relatively serious conditions at home without the need for any professional assessment of the levels of safety or hygiene in their property. Similarly, it is common when the doctor is overseeing a termination taking place within a hospital's premises is perhaps present in the same building but only reachable by phone, with no direct treatment delivered to the woman. This confirms that the safety of self-administering prescribed abortifacients, following strict guidelines in the comfort of one's home reaches a similar level as if delivered in a hospital.

Recent global events facilitated a short-term departure from mandatory compliance with the mentioned requirements encountered surrounding the administration of EMA. This ultimately confirmed the success of using telemedicine to access/deliver comprehensive medical abortion services remotely in a safe manner with high efficacy and high acceptability among women.[25] Studies suggest that Telemedicine medical abortion at home was used by almost 'nine out of ten women and, of these, only two out of ten women required a pre-abortion ultrasound whilst confirming high rates of complete abortion, low rates of complications and low rates of unscheduled contact'.[26] This confirms the efficacy of the treatment when the correct procedure and safeguards are being followed, and ensures women's safety is prioritised. It also meets the human rights obligations to ensure and guarantee pregnant individuals the highest standards of safety and quality.

There is no clinical need for licensed abortifacients to be solely administered in a clinical setting. If a woman's health has been assessed and it has been found that she does not have a condition that may create any danger to her health a woman's home is as safe as a medical setting to administer EMA. This is consistent with previous practise where abortifacients were often administered with a doctor's knowledge and ultimate responsibility, but it all took place without their physical presence.[27]

[25] Telemedicine medical abortion at home under 12 weeks' gestation: a prospective observational cohort study during the COVID-19 pandemic BMJ Journals available https://srh.bmj.com/content/early/2021/02/04/bmjsrh-2020-200976 accessed 21 February 2021.

[26] Finch RE, McGeechan K, Johnstone A, *et al*., 'Impact of self-administration of misoprostol for early medical abortion: a prospective observational cohort study', (2019), *BMJ Sex Reprod Health* 45:296–301 http://www.ncbi.nlm.nih.gov/pubmed/31422346 accessed 21 February 2021.

[27] *Royal College of Nursing of the United Kingdom v Department of Health and Social Security* [1981] AC 800 page 553.

Ultimately this confirms the expert consensus is that 'it is safer, more effective and better tolerated for women to administer the drugs in the privacy of their own residence'.[28] This emphasises that such practices facilitates the avoidance of 'the risk of distressing bleeding and pain on the journey home and removes the need for an extra visit to a clinic or hospital'[29] and upholds women's dignity and safety.

To continue providing enhanced patient-centred abortion services to pregnant women, the current telemedicine and EMA provision should be made permanent to ensure that this gender-specific service is delivered within a 'robust clinical governance framework which assures accessibility, clinical quality and patient 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 accessibility?

a) Yes, it has had a positive impact

Access to abortion medication via telemedicine has a significant positive impact on securing access to abortion services. The current temporary measures have had significant benefits for all pregnant individuals wanting to access abortion services, and these benefits are especially enjoyed by women who may have encountered significant barriers to accessing provision previously.

The right to healthcare is a fundamental right.[30] The ability to easily and effectively access healthcare is essential in the effective realisation of this right. This means goods and services must be accessible to all, including physical accessibility, especially for the most marginalised and vulnerable.[31] This has also been recognised by the UN's Human Rights

[28] RCOG, 'Clinical Guidelines for early Medical Abortion at Home- England', available https://www.rcog.org.uk/globalassets/documents/guidelines/early-medical-abortion-at-home-guideline-england.pdf accessed 21 February 2021.

[29] Lord, J, Regan, L, Kasliwal, A, Massey, L, and Cameron, S. 'Early medical abortion: best practice now lawful in Scotland and Wales but not available to women in England', BMJ Sex Reproduction Health 2018; 44:155.

[30] The right to health was first recognised as a basic human rights in Article 25 of the Universal Declaration of Human Rights (1948), and was subsequently codified in the International Covenant for Economic, Social, and Cultural Rights (ICESCR) in 1966, to which the UK became a state party in 1976.
An Nguyen, 'Challenges for Women with Disabilities Accessing Reproductive Health Care Around the World: A Scoping Review' (Sexuality and Disability, April 2020) 38:371–388) available at <https://link-springer-com.hallam.idm.oclc.org/article/10.1007/s11195-020-09630-7> accessed 22nd February 2021

[31]UN Committee on Economic and Social and Cultural Rights 'General Comment No.14: The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)' (2020) UN Doc. NO: E/C.12/2000/4. available at <https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2f2000%2f4&Lang=en> accessed 22nd February 2021

Committee in its decision of the Mellet v Ireland case in 2016 where it stated, States 'must ensure that abortion is actually accessible should a woman meet the domestic legal requirements.'[32] 'Denial of access to abortion has been identified as a form of gender- based discrimination against women, which can amount to torture and/or cruel, inhuman and degrading treatment.'[33] This results in discrimination in outcome, and therefore indicates a State's failure to fulfil their duty to respect and protect women from discrimination in all forms, including direct and indirect discrimination.[34]

Accessibility has been interpreted by the UN to have four components: non-discrimination, physical accessibility, affordability, and information accessibility.[35] Despite this requirement, abortion medication and reproductive services have not been accessible to all. This is especially pertinent to women who are differently-abled, full-time carers, women who live in rural areas with reduced public transport/without independent transport and ethnic minority women who may operate within a culture of constraints, which significantly affects their independence, travel and time away from home. [36]

Studies on health care services for people with disabilities has also demonstrated an inaccessible environment which has limited easy access to appropriate resources and treatment.[37] Whilst some modifications are in place within clinics and hospitals, travel remains a significant obstacle restricting many women's access to healthcare provision generally. Studies have indicated that people with disabilities experience difficulties accessing sexual and reproductive health care services.[38] In almost all of the reviewed cases in a 2020 study 'women with disabilities lacked access to reproductive health care services

[32] Fiona De Londras, 'Fatal Foetal Abnormality, Irish Constitutional Law, and Mellet v Ireland' (2016) [24 (4) Medical Law Review, 598]

[33] 'Abortion' (United Nations, Human Rights Office of the High Commissioner, 2020) available at <https://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf> accessed 22nd February 2021

[34] 'The UN Convention on the Elimination of All Forms of Discrimination against Women: A Commentary' M. A. Freeman, C. Chinkin, B. Rudolf (eds) (OUP, 2013) 469

[35] UN Committee on Economic and Social and Cultural Rights 'General Comment No.14: The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)' (2020) UN Doc. NO: E/C.12/2000/4. available at <https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2f2000%2f4&Lang=en> accessed 22nd February 2021

[36] Carrie Purcell and others, 'Toward normalising abortion: findings from a qualitative secondary analysis study, Culture, Health & Sexuality' (2020) 22:12, 1349-1364 <https://www.tandfonline.com/doi/full/10.1080/13691058.2019.1679395> accessed 22nd February 2021

[37] An Nguyen, 'Challenges for Women with Disabilities Accessing Reproductive Health Care Around the World: A Scoping Review' (Sexuality and Disability, April 2020) 38:371–388) <https://link-springer-com.hallam.idm.oclc.org/article/10.1007/s11195-020-09630-7> accessed 22nd February 2021

[38] An Nguyen, 'Challenges for Women with Disabilities Accessing Reproductive Health Care Around the World: A Scoping Review' (Sexuality and Disability, April 2020) 38:371–388) <https://link-springer-com.hallam.idm.oclc.org/article/10.1007/s11195-020-09630-7> accessed 22nd February 2021

because of practical (transportation difficulties; long waiting times) and physical (limited infrastructure)' issues.[39]

For abortion services, access is especially complicated if pregnant people are dependent upon carers to facilitate their access, especially if their carer is also their partner, and this complexity is further compounded if their carer is also abusive towards them. Evidence demonstrates that domestic abuse spikes during pregnancy,[40] and that disabled women are twice as likely than non-disabled women to be abused.[41] For as 'long as abusive men have been coercing and controlling the lives and minds of their victims they have also been controlling their bodies'.[42] As a result of the abuse suffered by women, many 'domestic violence victims are often forced to buy abortion medication online to illegally end their pregnancy because they cannot get to a clinic.[43] Mainly, because they can not escape their abuser, and most certainly not on numerous occasions for consultations and then to take medication. One provider of online pills estimates that 33% of requests from Great Britain cite domestic abuse as a reason they cannot access legal abortion care.[44]

The ability to take an abortion pill at home would remove these barriers for disabled women and allow them to access the medication, ensuring their right to health is met. Disabled women therefore must have access to telemedicine and EMA services via post if their ability to access provision is going to be upheld.

Young girls who are unable to access abortion medication because of physical and mental constraints will also benefit from telemedicine access at home. Teenagers are more affected by logistical barriers to abortion than older women.[45] 0.6% of abortions in 2018 were carried out on girls aged 16 and only 0.2% of abortions were carried out on girls under 15 years old.[46] Such low rates may be because of the barriers that young girls face in accessing abortion, most crucially, travel to the centre. Even though family members do not need to

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[39] An Nguyen, 'Challenges for Women with Disabilities Accessing Reproductive Health Care Around the World: A Scoping Review' (Sexuality and Disability, April 2020) 38:371–388) <https://link-springer-com.hallam.idm.oclc.org/article/10.1007/s11195-020-09630-7> accessed 22nd February 2021

[40] 'Domestic Abuse in Pregnancy' (*NHS*, March 2018) <https://www.nhs.uk/pregnancy/support/domestic-abuse-in-pregnancy/> accessed 22nd February 2021

[41] 'Support for Disabled Women' (*Women's Aid*, Maintained) <https://www.womensaid.org.uk/the-survivors-handbook/the-survivors-handbook-disabled-women/> accessed 22nd February 2021

[42] Brenna Jesse 'What does abortion have to do with domestic violence anyway? (*Scottish Women's Aid*, 2018) <https://womensaid.scot/what-does-abortion-have-to-do-with-domestic-abuse-anyway/> accessed 22nd February 2021

[43] Alisha Berry Ryan, 'Domestic Abuse Bill and Abortion' (*Abortion Rights*, 2020) <https://abortionrights.org.uk/the-domestic-abuse-bill-and-abortion/> accessed 22nd February 2021

[44] Alisha Berry Ryan, 'Domestic Abuse Bill and Abortion' (*Abortion Rights*, 2020) <https://abortionrights.org.uk/the-domestic-abuse-bill-and-abortion/> accessed 22nd February 2021

[45] 'Abortion Care, Accessibility and Sustainability of Abortion Services' (*National Institute for Health Care and Excellence,* September 2019) <https://www.nice.org.uk/guidance/ng140/evidence/a-accessibility-and-sustainability-of-abortion-services-pdf-6905052973> accessed 22nd February 2021

[46] 'Abortion Statistics in England and Wales' (*Department of Health and Social Care,* 13 June 2019) <Abortion Statistics England and Wales 2018 1 .pdf> accessed 22nd February 2021

be informed when a young girl accesses abortion, they advise coming with a family member which will be very difficult for the young woman if she does not want to share this information.[47] This is a significant problem in the UK as 1 in 4 girls suffer from some form of abuse.[48] In addition, the onerous administrative requirements to access abortion services make safe access to this essential health care extremely difficult for young women.[49]

The UN's Human Rights Committee, in Mellet v Ireland, made clear how access to abortion is essential when seeking to ensure there is "effective and equal empowerment of women".[50] In this same opinion Sarah Cleveland highlighted the groups of women that may be disproportionately negatively affected, particularly identifying: differently-abled, rural women, and women suffering from domestic violence.[51]

Making the temporary changes permanent and creating an enabling legal framework for women to be able to access abortion services at home will remove these barriers for women. It will create more accessible access to abortion for all women in England, and particularly increase safe, legal and accessible abortion service to some of the most vulnerable women in our society.

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?- Alice.

a) Yes, it has had a positive impact

The current temporary measures providing early medical abortion via telemedicine has had a positive impact on women's access to abortion with regards to their privacy and confidentiality. Without the existing telemedicine and postal services, a pregnant person may fear that their privacy or confidentiality may not be protected, and this may create significant barriers to accessing abortion services. Some women may fear being seen by someone that is known to them or their partner or family or getting judged in a negative manner for using the service it provides. Those who live in small, close-knit communities may be reluctant to use abortion clinics because they may not want anyone to know they are pregnant or seeking abortion services. Those within religious communities who wish to

[47] 'Under 16 and considering abortion' (*BPAS*, Maintained) <https://www.bpas.org/abortion-care/under-16/> accessed 22nd February 2021
[48] 'The State of Girls Rights in the UK' (*Plan International UK*, May 2020) <https://plan-uk.org/file/plan-uk-state-of-girls-rights-coronavirus-reportpdf/download?token=gddEAzlz> accessed 22nd February 2021
[49] Europe: Failures to guarantee safe access to abortion endangers health of women, girls amid COVID-19 (*Amnesty International,* April 2020) <https://www.amnesty.org/en/latest/news/2020/04/europe-failures-to-guarantee-safe-access-to-abortion-endangers-health-of-women-and-girls-amid-covid-19/> accessed 22nd February 2021
[50] *Mellet V Ireland* [2016] CCPR/C/116/D/2324/2013 (UN Human Rights Committee) [7] (Sarah Cleveland)
[51] *Mellet V Ireland* [2016] CCPR/C/116/D/2324/2013 (UN Human Rights Committee) [7] (Sarah Cleveland)

have an abortion may refuse to go to an abortion clinic because doing so may result in encountering criticism from protestors. Many religions forbid abortion and encourage those who are pregnant to complete their pregnancy, so one may worry that they could be disowned from their family or ostracised by their community for accessing an abortion, or even for being outside of marriage if they are un-married, widowed, or divorced. These examples demonstrate that having other options for accessing abortion, like permanent home administration of EMA medication, would be useful for people in such situations. Having this service available permanently would make people in these types of situations more included in the accessibility of abortion, and it would respect their "fundamental right to privacy".[52]

Women may feel that they have no other choice but to access abortion medication illegally if they do not want to acquire it from a clinic or if the option of having both pills sent to their home is taken from them. Illegal medications are not regulated and pose additional health risks to women. Making the current temporary measures permanent will not only reduce this risk, but it will also secure women's right to health as found in Article 12(1) of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which the UK ratified in 1986, thereby accepting its legal obligations. It will also ensure that women are not denied forms of healthcare they require on account of being women. Restricting access to a healthcare requirement only women need would discriminate against them on the basis of sex, and go against the CEDAW's provisions as laid out in General Recommendation No. 24[53], stating that state parties should "take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care and services, including those related to family planning."[54] Not providing women with access to abortion could also constitute a breach of Articles 3 (not being subject to torture or inhuman or degrading treatment) and 8 (right to private and family life) European Convention of Human Rights (ECHR) 1950, which the UK is also a state party to.

Securing women's access to EMA via telemedicine and the posting of abortifacients to women's homes on a permanent basis will enable people to administer their abortions with safe medication supplied by a medical practitioner, rather than use risky, illegal medication. It will allow people perform their abortions in the comfort of their own home, where they would have privacy, comfort and safety. Lord Kerr's opinion in the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review [55] was that a "termination of pregnancy is one of life's most traumatic and fraught experiences"[56], and it

[52] Abortion Rights Campaign, 'Privacy & Abortion' (Abortion Rights Campaign) <https://www.abortionrightscampaign.ie/right-to-privacy/> accessed 21 February 2021.
[53] (20th session, 1999).
[54] CEDAW General Recommendation No. 24 (20th session, 1999), Article 12(1) <https://www.ohchr.org/FR/ProfessionalInterest/Pages/CEDAW.aspx> accessed 26 February 2021.
[55] (Northern Ireland) Reference by the Court of Appeal in Northern Ireland pursuant to Paragraph 33 of Schedule 10 to the Northern Ireland Act 1998 (Abortion) (Northern Ireland), [2018] UKSC 27, [2018] H.R.L.R. 14.
[56] Ibid, para 238.

is "deeply upsetting"[57] that some have to travel to foreign areas where they lack the support that they would want in order to have an abortion. People should not have to sacrifice or compromise their right to safety, comfort and dignity to access abortion services, especially when safe, affordable, and accessible alternatives are not only possible but are already in place. In our opinion, recognition of a pregnant person's home as an approved place must continue and the Abortion Act 1967 should be amended.

The current measures give women the option to either attend "an approved place"[58], have "a consultation with an approved place via video link, telephone conference or other electronic means"[59], or have "a consultation with a registered medical practitioner via video link, telephone conference or other electronic means"[60], so people have a choice on how they would like to access the medication. Giving people the option to talk with a medical practitioner by a (video) call removes the anxiety that some may possibly face if they were to attend an abortion clinic in person. If one wanted to go about the process in an even further private manner, they could speak to someone just by telephone, so that there is no face-to-face interaction by a video chat.

Prior to the 2018 policy that enabled women to take the second medication, misoprostol, at home after they received the first medication in an approved place research had shown that "women who had been administered misoprostol [in a clinic] had begun to miscarry on the journey between the approved clinic and their home, causing significant distress"[61]. If people had the option to have an EMA at their home permanently, this would remove this discomfort and distress as women would be able to go through the abortion process within the comfort and safety of their own home. Having the severely traumatic experience of having an abortion is enough for one to go through without having to suffer a miscarriage on the way home from a clinic; this would exacerbate the situation and be extremely cruel. If r the option of having an EMA at home was removed, women would be subject to a

[57] Ibid.

[58] Mark Davies, 'The Abortion Act 1967 – Approval of a Class of Places, Department of Health and Social Care' (Gov.uk, 30 March 2020) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876740/30032020_The_Abortion_Act_1967_-_Approval_of_a_Class_of_Places.pdf> accessed 21 February 2021, para 4(a)(i).

[59] Mark Davies, 'The Abortion Act 1967 – Approval of a Class of Places, Department of Health and Social Care' (Gov.uk, 30 March 2020) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876740/30032020_The_Abortion_Act_1967_-_Approval_of_a_Class_of_Places.pdf> accessed 21 February 2021, para 4(a)(ii).

[60] Mark Davies, 'The Abortion Act 1967 – Approval of a Class of Places, Department of Health and Social Care' (Gov.uk, 30 March 2020) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876740/30032020_The_Abortion_Act_1967_-_Approval_of_a_Class_of_Places.pdf> accessed 21 February 2021, para 4(a)(iii).

[61] BMA, 'The law and ethics of abortion' (BMA, September 2020) <https://www.bma.org.uk/media/3307/bma-view-on-the-law-and-ethics-of-abortion-sept-2020.pdf> accessed 21 February 2021; British Pregnancy Advisory Service, 'Home use of misoprostol' (BPAS) <www.bpas.org/get-involved/campaigns/briefings/home-use-of-abortion-drugs/> accessed 21 February 2021.

violation of their Article 3 right[62], the right to be free of torture or inhuman, degrading treatment.

Giving people the option to have an EMA from home permanently gives people more of a choice on how they want to access abortion, enhancing their bodily autonomy. *Mellet v Ireland*[63] exemplified how one's right to privacy (Article 17 ICCPR and Article 8 ECHR 1950) can be breached when the choice of how to have an abortion is taken away. Mellet had to travel overseas to have an abortion because having one in Ireland was illegal, causing her extreme stress and upset. *Mellet v Ireland*[64] is one of many abortion-related cases that shows how women are still being discriminated against, based on their gender, by restricting their freedom in the choices that they make regarding their reproductive functions. Women who may not have access to abortion services arising from privacy and confidentiality issues would be targeted specifically if the home administration of EMA was not made available permanently, which could constitute a breach of Article 14[65], that protects people from discrimination on the basis of sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status. If the choice of taking both pills at home was removed, it would make those who cannot access abortion through another method more vulnerable. Having the choice to abort a pregnancy is a right under CEDAW which should be respected by the Department of Health and Social Care. If the option of having a home administered EMA was no longer available, this right would be taken away and make women's access to abortion heavily restricted. The permanent removal of EMA via telemedicine would prevent some women from accessing abortion completely, which could have dire physical and mental health consequences.

[62] European Convention on Human Rights, 1950.
[63] (2016) CCPR/C/116/D/2324/2013 (UN Human Rights Committee).
[64] Ibid.
[65] European Convention on Human Rights, 1950.

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?- Millie

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?

Abortion care is an essential part of health care for women. However, It is clear that Black, Asian and minority ethnic (BAME) women are discriminated against in their ability to access reproductive health care.[66] Discrimination against minorirised women in their access to the healthcare they have a right to is not restricted to what happens in England, we have an obligation to ensure all women have the highest attaininable standards of health and existing socio-economic inequalities are not perpetuated.[67]

When health care services are not equally accessible to all women the most vulnerable women in society are most at risk of having their rights violated and inequalities exacerbated. A transformative equality approach, which seeks to both redress disadvantage and accommodate difference by responding to the needs of communities to achieve structural change would allow women from all groups and communities to access both pills for EMA at home. Additionally, ethnic minority groups are more likely to live in areas of deprivation as demonstrated by Henderson (2013)[68]. By allowing women to access both abortion pills at home, the economic barrier is also removed for BAME women. In CESCR' General Comment 14, states "Health facilities, goods and services have to be accessible with non-discrimination physical accessibility; within safe physical reach for all sections of the population, economic accessibility to ensure that it is affordable; equity demands that poorer households should not be disproportionately affected by prices and information accessibility within the jurisdiction of the State party."[69] This demonstrates the principles that states must follow to ensure women's rights are effectively acknowledged. By changing the way abortion medication can be accessed, it is likely to be in compliance with this, by allowing women with minority ethnic backgrounds easier access to abortion care for women and girls who may otherwise face barriers in accessing service provision.

It is important that abortion services are made available to women from all backgrounds, including migrant and Traveller women, and without a determination of their right to residence or citizenship. Recommendation 11 issued by The Royal College of Obstetricians & Gynaecologists in (2019) identifies that "CCGs must commission abortion care services

[66] Jane Henderson, Haiyan Gao and Maggie Redshaw, 'Experiencing maternity care: the care received and perceptions of women from different ethnic groups' (2013), 13(196), BMC Pregnancy and Childbirth, page 2 <https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-13-196> accessed 26/02/2021.
[67] Alyne da Silva Pimentel Teixeira (deceased) v. Brazil, CEDAW/C/49/D/17/ 2008, August 10, 2011 (para 7.7)
[68] Jane Henderson, Haiyan Gao and Maggie Redshaw, 'Experiencing maternity care: the care received and perceptions of women from different ethnic groups' (2013), 13(196), BMC Pregnancy and Childbirth, Page 2<https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-13-196> accessed 26/02/2021.
[69] CESCR General Comment No.14: The right to the highest attainable standard of health (2000) UN Doc. NO: E/C.12/2000/4, 11 August 2000

which implement, or are seeking to implement recommendations to ensure women have a choice of procedure and guarantee quick access to services."[70] Quick access to emergency procedures and services could be vital to migrant and Traveller women. By allowing them to take both pills at home, it removes the limitation of travelling to health care clinics which could be costly and timely when in desperate need. "All women should be able to access abortion care easily and without fear of penalties or harassment."[71] This should include information regarding residence or citizenship. "The Department of Health and Social Care (DHSC) must review and expand the definition of "home" under the Abortion Act 1967[72]."[73] This expansion of the definition could be crucial to include women who do not fit under the current definition, yet need help and access to the services.

As every form of contraception has a failure rate, but the consequence of failed contraception is only borne by women, women need to have healthcare options to respond to unwanted pregnancies. The right to freedom from discrimination[74], the right to freedom from inhuman and degrading treatment[75] and the right to life[76] are all breached if healthcare access is denied. Therefore the State is breaching Article 14, 15, 2 of the European Convention on Human Rights and the Convention on the Elimination on the Discrimination Against Women. All of these human rights are universally agreed norms which coexist and are supportive of each other, this means they do not exist in isolation. Thus, denying a woman access to vital health care services, denies her the right to bodily autonomy, dignity and freedom from discrimination on the basis of sex.

Furthermore, simply offering the abortion pill itself does not ensure women have the right to choice when it fails to include women who may struggle to access these health care services. "Access to health care services is widely seen as a basic human right. However, for people with disabilities, this right is seemingly not recognized. Studies on health care services for people with disabilities have demonstrated that an inaccessible environment, [and] insensitive health care providers were recognized as the main obstacles, which limit easy access to appropriate resources and treatment."[77] This highlights discrimination in treatment and outcome.

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[70] 'Better for women' (Royal College of Obstetricians & Gynaecologists December 2019) <https://www.rcog.org.uk/globalassets/documents/news/campaigns-and-opinions/better-for-women/better-for-women-full-report.pdf > date accessed 20/02/21 Page 15-16

[71] 'Better for women' (Royal College of Obstetricians & Gynaecologists December 2019) <https://www.rcog.org.uk/globalassets/documents/news/campaigns-and-opinions/better-for-women/better-for-women-full-report.pdf > date accessed 20/02/21 Page 15-16

[72] The Abortion Act 1967

[73] 'Better for women' (Royal College of Obstetricians & Gynaecologists December 2019) <https://www.rcog.org.uk/globalassets/documents/news/campaigns-and-opinions/better-for-women/better-for-women-full-report.pdf > date accessed 20/02/21 Page 15-16

[74] European Convention on Human Rights 1953 Article 14

[75] European Convention on Human Rights 1953 Article 15

[76] European Convention on Human Rights 1953 Article 2

[77] (Challenges for Women with Disabilities Accessing Reproductive Health Care Around the World: A Scoping Review, An NguyenPublished online: 9 April 2020 Springer Science+Business Media, LLC, part of Springer Nature 2020)

A substantive equality approach requires States to adopt measures that will result in equality in outcome for disadvantaged groups by responding to the individual's specific needs. "Some studies have indicated that people with disabilities experience difficulties accessing sexual and reproductive health care services."[78] The Equality Act[79] prohibits state institutions, like the NHS, from discriminating against individuals or groups of individuals either directly (in treatment) or indirectly (in outcome).

The state has an obligation to respect, protect and fulfil thier human right commitments and to ensure the prevention of this discrimination and any discrimination that may arise should be punishable by the state.[80] "Research has highlighted the specific issues that differently abled individuals have when trying to access reproductive health services. One research group found that in almost all of their reviewed studies 'women with disabilities lacked access to reproductive health care services because of practical (transportation difficulties; long waiting times) and physical (limited infrastructure)".[81] The ability to take an abortion pill at home would remove these physical barriers for disabled women, and ensure the right to freedom of discrimination, the right to health, privacy, bodily autonomy, and the right to life with dignity are complied with. In a survey of experiences of disabled women regarding health care, it was noted that "Only 19% of women thought that reasonable adjustments or accommodations had been made for them"[82] and "more than a quarter of women felt that their rights were either poorly or very poorly respected."[83] This collates that not enough is being done by the State to protect women's health care rights. Disabled women should be properly accommodated as this is essential to upholding their dignity. This is especially important from a public sector equality duty perspective to avoid perpetuating existing social inequalities and levelling up the health care provision that disabled women have access to.

Religion should also be considered in relation to accessing abortion care. Some religious groups may find it difficult to access health due to their beliefs. A woman or girl living at

[78] (Challenges for Women with Disabilities Accessing Reproductive Health Care Around the World: A Scoping Review, An NguyenPublished online: 9 April 2020 Springer Science+Business Media, LLC, part of Springer Nature 2020)
[79] The Equality Act 2010
[80] Chinkin, C. 'Violence Against Women', as in The UN Convention on the Elimination of all Forms of Discrimination Against Women: A Commentary' (OUP, 2013)
[81] (Challenges for Women with Disabilities Accessing Reproductive Health Care Around the World: A Scoping Review, An NguyenPublished online: 9 April 2020 Springer Science+Business Media, LLC, part of Springer Nature 202
[82] Jenny Hall, Vanora Hundley, Bethan Collins, and Jillian Ireland, 'Dignity and respect during pregnancy and childbirth: a survey of the experience of disabled women' (2018), 18(328), BMC Pregnancy and Childbirth, page 7 <https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-018-1950-7> accessed 23/02/2021.
[83] Jenny Hall, Vanora Hundley, Bethan Collins, and Jillian Ireland, 'Dignity and respect during pregnancy and childbirth: a survey of the experience of disabled women' (2018), 18(328), BMC Pregnancy and Childbirth, page 8<https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-018-1950-7> accessed 23/02/2021.

home may be prevented from visiting the health clinic for an abortion, thus denying her right to her own bodily autonomy. The same goes for a woman or girl who has sexual intercourse before marriage, perhaps of Catholic belief, they may struggle to access abortion care services due to fear of rejection from their family. Accessing abortion care is perhaps a stressful time for any woman; particularly a woman whose beliefs do not allow this type of procedure. Thus, accessing this medication should be made as easily as possible, to minimise the amount of obstacles women have to face. The termination of pregnancy in all of its forms, both medically and surgically, has fewer risks the earlier that it is performed.[84] Therefore, by allowing women to access the medication at home they can access it quicker, with less obstacles to face.

In America women were denied their right to health care; "Abortion ban linked to dangerous miscarriages at Catholic hospital, report claims."[85] This shows how cultural/religious restrictions can interfere with emergency care. When religious beliefs interfere with emergency care, it also interferes with a woman's right to life (Article 2)[86] and freedom from discriminatory treatment (Article 14)[87].

Allowing women to have access to both abortion pills at home after the COVID-19 pandemic would ensure the state's obligations to; respect, protect and fulfil women's needs, are met.[88] Accessing both pills at a health care clinic has been proven difficult for women, particularly: BAME women. BAME women typically access the health care provision later in their pregnancies and as a result have poorer birth outcomes, including low birthweight and longer hospital stays.[89] Fast and easy access to forms of service delivery will especially benefit BAME women due to their disproportionate experience of delays in accessing health care institutions. Therefore in contemporary society, it is necessary to remove physical barriers that women face to prevent any discriminatory and degrading treatment, to protect women's dignity.

[84] 'Methods of abortion' (Ethics Guide BBC 2014) <http://www.bbc.co.uk/ethics/abortion/medical/methods_1.shtml> date accessed 26/02/21.
[85] Molly Redden, 'Abortion ban linked to dangerous miscarriages at Catholic hospital, report claims' (The Guardian, Feb 2016) <https://www.theguardian.com/us-news/2016/feb/18/michigan-catholic-hospital-women-miscarriage-abortion-mercy-health-partners> date accessed 21/02/21.
[86] European Convention on Human Rights 1953 Article 2
[87] European Convention on Human Rights 1953 Article 14
[88] Chinkin, C. 'Violence Against Women', as in The UN Convention on the Elimination of all Forms of Discrimination Against Women: A Commentary' (OUP, 2013)
[89] Jane Henderson, Haiyan Gao and Maggie Redshaw, 'Experiencing maternity care: the care received and perceptions of women from different ethnic groups' (2013), 13(196), BMC Pregnancy and Childbirth, Page 2 & 10 <https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-13-196> accessed 26/02/2021.

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?- Beth

Making permanent home use of both pills for EMA would significantly reduce inequality/difference in access to abortion between women from deprived backgrounds and communities in the UK.

Paragraph 12 of the CESCR's General Comment 14 imposes the concept that "The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party[90]." Thus, meaning that the State has immense power over the rights people have and whether or not they are able to access them. The right to health must be enjoyed without discrimination on the grounds of race, age, ethnicity or any other status. The WHO Constitution (1946) envisages "…the highest attainable standard of health as a fundamental right of every human being[91]". Non-discrimination and equality require states to take steps to redress any discriminatory law, practice or policy.

The CESCR's General Comment 14 considers accessibility to be a major reason as to why many women are disadvantaged. It states that "accessibility to health facilities, goods and services have to be accessible with non-discrimination[92]". Although, this may be harder to achieve in reality, as evidenced in the case of Alyne da Silva Pimentel Teixeira (deceased) v. Brazil,"the Committee concludes that Ms. da Silva Pimentel Teixeira was discriminated against, not only on the basis of her sex, but also on the basis of her status as a woman of African descent and her socio-economic background[93]".

This includes "physical accessibility [within safe physical reach for all sections of the population][94]." This can be difficult to achieve because studies on health care services for people with disabilities have demonstrated an inaccessible environment which has limited easy access to appropriate resources and treatment[95]]". As a result, physical access is limited to those with disabilities.

Furthermore, "economic accessibility [affordable; equity demands that poorer households should not be disproportionately affected by prices][96]". However, many women from

[90] Paragraph 12 CESCR's General Comment 14
[91] https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health
[92] Paragraph 12 CESCR's General Comment 14
[93] Alyne da Silva Pimentel Teixeira (deceased) v. Brazil, CEDAW/C/49/D/17/ 2008, August 10, 2011 (para 7.7)
[94] Paragraph 12 CESCR's General Comment 14
[95] An Nguyen, 'Challenges for Women with Disabilities Accessing Reproductive Health Care Around the World: A Scoping Review' (April 2020, Sexuality and Disability (2020) 38:371–388) available at <https://link-springer-com.hallam.idm.oclc.org/article/10.1007/s11195-020-09630-7>
[96] Paragraph 12 CESCR's General Comment 14

disadvantaged backgrounds will not have the means to receive access due to their financial position. This disproportionately affects groups without the means or finances to travel further or those who struggle to navigate the increasingly complex system. For example, the greatest difficulty I have is the distance between my house and the health post…[97].

As well as, "information accessibility [resources - Mellet v Ireland[98] - information that affects you, seek, receive and impart that information impartially - never told about anything but to travel[99]]". Access to information is paramount in helping women and girls, many are unaware in the treatment they can receive.

In addition, it has to be "within the jurisdiction of the State party.[100]" This demonstrates the principles that states must follow to ensure women's rights.

The above demonstrates the need for reform and how changing the way abortion medication, it is likely to be in compliance with Human Rights Act[101], by allowing women with strained resources to access pills easily online and can increase the access to abortion for women and girls who are more deprived.

Although, there is no specific right to abortion care under the European Convention on Human Rights[102], the right to freedom from discrimination[103], the right to freedom from inhuman and degrading treatment[104], and the right to life[105] are all breaches if health care access is denied.

When considering the Abortion Act[106] itself, it can be argued that it is outdated and not suited to protect women and girls in today's society. As evidenced in the case of Pro-Life Scotland Limited, v Scottish Ministers[107]: "It would be as wrong today to adopt a literal interpretation of the 1967 Act that produced an absurd result as it would have been in 1980 when Royal College of Nursing was decided." This case surrounds whether access to abortion can be performed other than in a hospital setting, it demonstrates that women's needs are different in contemporary society to how they were when abortions could only be performed in the hospital. Thus, access to abortion from home is plausible and would benefit women from deprived backgrounds/between geographical locations.

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[97] layout 1 (amnesty.ca)
[98] Mellet v Ireland (2016) CCPR/C/116/D/2324/2013 (UN Human Rights Committee)
[99] Paragraph 12 CESCR's General Comment 14
[100] Paragraph 12 CESCR's General Comment 14
[101] Human Rights Act 1998
[102] European Convention of Human Rights
[103] European Convention of Human Rights, Article 14
[104] European Convention of Human Rights, Article 15
[105] European Convention of Human Rights, Article 2
[106] Aborton Act 1967
[107] SPUC Pro-Life Scotland Limited, v Scottish Ministers, Judicial Review of the Decision to issue the Abortion Act 1967 (Place for Treatment for the Termination of Pregnancy) (Approval) (Scotland) 2017, [2018] CSOH 85, para 41.

It can be argued that allowing both pills for EMA to be taken at home can have a wider impact globally as it allows women's control over when to have children and how many children to have plays a crucial role in improving mat*ernal health, reducing infant mortality and reducing poverty, as women are better able to participate in economic life*[108].

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

When discussing whether to make EMA accessible at home on a permanent basis, it is important, from a rights-based approach, to discuss the impact of formal and substantive equality. Formal equality requires women and men to be treated alike, however, it fails to recognise that different factors may impact a woman's access to abortion and perpetuate existing forms of inequality.[109] Further an equal treatment approach may not be able to respond to the specific needs and barriers individuals and groups may experience, such access requirements for disabled people, outreach programmes for BAME women, sensitive and approachable services for girls under 18, or non-cis-gender pregnant individuals etc. Substantive equality aims to redress these limitations by accepting that different treatment is not discriminatory when it is seeking to achieve equality in outcome.[110] Making EMA accessible at home on a permanently basis will fulfil substantive equality by tailoring the health care services to women's individual needs, such as women who perhaps cannot afford to travel, fears being seen, or who may struggle to get access to an abortion due to their culture, disability, or caring/work commitments.

Guaranteeing access to EMA via telemedicine on a permanent basis would also be consistent and comply with the Convention on the Elimination of All Forms of Discrimination against Women Article 12 (right to health), which states "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."[111] For individuals with the capacity to become pregnant to have equality in outcome they must have all of their healthcare needs available, accessible, and of good quality for their right to equality to be effectively realised. This includes the ability to access abortion services in a way that does not disadvantage vulnerable or minoritized groups. For equality to be meaningful women must be able to access healthcare that only women need including abortion services, midwifery lead support, pre- and post-natal support, including mental health support such as but not limited to post-natal depression. Claire Lougarre reinforces this point by finding these types of equality combined to ensure everyone's entitlement to the 'highest health attainable'.[112]

[108] UN Sustainable Development Goals, Goal 3 of Good Health and Wellbeing
[109] Daniel Moeckli, Sangeetha Shah & Sandesh Sivakumaran (eds), 'Equality and Non-Discrimination' International Human Rights Law (OUP 2018) 149.
[110] Ibid, 150.
[111] CEDAW General Recommendation No.24 (20th Session, 1999) Article 12: Women and Health <https://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24> accessed 09/02/2021.
[112] Claire Lougarre, 'Clarifying the Right to Health through Supranational Monitoring: The Highest Standard of Health Attainable' (2018), 11(3), Public Health Ethics, 251.

This approach also allows equitable access which is 'fundamental to achieving the Sustainable Development Goals by 2030'.[113]

Ensuring that the public sector, such as the NHS, does not discriminate against women, particularly disabled, young, non-cis-gender, or BAME/minoritized women requires '...appropriately taking gender into account',[114] redistributing 'power and resources',[115] and the 'removal of barriers but also positive measures to bring about change'.[116] Guaranteeing the permanent use of EMA at home via telemedicine will give women greater autonomy and privacy and protect their rights as women.[117] It will also be consistent with the scientific (medical abortion) and technological (video-conferencing) developments that have occurred since the Abortion Act 1967 was drafted and modernise its provisions in a way that upholds women's safety and welfare and is reflective of current abortion practise where over 50% of abortions that took place in June last year were EMA telemedicine appointments. Experience tells us the current approach works and it must continue to uphold women's rights to equality, privacy, and bodily autonomy and to prevent discrimination from hitting minoritized women disproportionately and resulting in a violation of public sector equality duties under the Equality Act 2010.

To comply with the Equality Act's requirements to reduce inequalities in outcome which result from socio-economic disadvantage the government must aim to achieve equality in outcome. To achieve this the government and can focus on complying with the 'respect, protect' fulfil' framework (CEDAW GR 28 (2010)) and to put in place.

If the state does not provide access to telemedicine for early medical abortion, as a consequence, the state will not fulfil their duty to respect, that has been understood by international expert committees, through discrimination, that would fall short of the Equality Act. This discrimination would occur on the basis that some women will not be able to travel for abortion medication due to specific circumstances, including disability, culture, and socioeconomic status, meaning that not all women are guaranteed access to abortion medication. It is worth elaborating on the state's obligations to respect, protect, promote, and fulfil. These obligations will be discussed with primary regard to the case of *LC v Peru (2011)*. The obligation to respect entail seemingly 'neutral' laws should not discriminate against women, by ensuring that officials are 'fully familiar with applicable legal provisions and … sensitised to all forms of violence against women and respond adequately to them'.[118] By allowing access to abortion at home, it would highlight this obligation, by

[113] 'Women's Lives, Women's Rights: Strengthening Access to Contraception Beyond the Pandemic' (All Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2020) <file:///C:/Users/User/Downloads/women-s-lives-women-s-rights-full-report-100920.pdf> accessed 21st February 2021.
[114] Andrew Byrnes, M. A. Freeman, C. Chinkin, B. Rudolf (eds) 'Article 1, The UN Convention on the Elimination of All Forms of Discrimination against Women: A Commentary.' (OUP, 2013) 55.
[115] Ibid.
[116] Ibid.
[117] Ibid.
[118] Chinkin, C. 'Violence Against Women', as in The UN Convention on the Elimination of all Forms of Discrimination Against Women: A Commentary' (OUP, 2013), 469.

demonstrating the state's understanding of the sensitive nature of women's issues, that can be affected by their socio-economic situation, culture or psychological harm. An example that clearly illustrates the need for compliance to these obligations is *LC v Peru (2011)*, whereby a minor was raped, and diagnosed with moderate anxiety-depression, but was not considered for mental health treatment as a form of rehabilitation.[119] This breach is exacerbated through the failure to consider the individual's needs, who had unfortunately attempted suicide due to the circumstances surrounding the pregnancy and the fear. This shows the importance to respect women's needs for access to abortion, because it can have serious effects on the pregnant women. By only merely giving women the option to have an abortion is not enough to fulfil this right, there must be a means of access that does not discriminate against women, especially those in a vulnerable position. Other services that are advocating for improving health outcomes, including the BMJ, have urged the Secretary of State for Health [and Social Care] to use his powers to extend to women in England the same compassion, respect, and dignity that the Scottish and Welsh governments have announced, so that all women can access safe, effective abortion care."[120] This emphasises that there is a strong recognition that access to EMA permanently from home may contribute to the enhancement of women's reproductive rights, by applying an intersectional lens, to encompass factors of women's life that may adversely affect their access to abortion, including, but not limited to, cultures, disabilities and BAME women. This is evidenced by citing data on 28,000 women from one of the UK's largest abortion providers, that found that access to abortion other than in the home "...selectively disadvantages the most vulnerable - those who are deprived, live in rural areas or have dependants..."[121] As such, through the recognition that not all women are capable of accessing abortion at health care centres, and applying the law permanently to the home, would enhance the state's obligation of respect, by allowing women greater access when faced with a multitude of disadvantages.

Ensuring access to telemedicine for early medical abortion would be consistent with the state's obligation to protect, through a due diligence approach, by enabling all women to have access to EMA through non-discriminatory conduct. The state's obligation to protect is a positive obligation that involves 'combating a climate of impunity and silence whereby violence is socially legitimated, and women suffer extreme violence without criminal accountability for perpetrators'.[122] This also involves non-discrimination via state and non-state actors, that involves the enforcement of legislation to enforce women's rights and protections. As within the case referred to, *LC v Peru*, the state should have acted as if they had a 'double duty' to prevent the minor from being discriminated against both by her age, and by her reproductive rights.[123] It has been of the opinion that not adopting women's

[119] LC v Peru (2011) CEDAW/C/50/D/22/2009 (UN CEDAW Committee), para 2.10.
[120] 'Allow women in England to take second abortion pill at home, healthcare leaders urge' (BMJ) <https://www.bmj.com/company/newsroom/allow-women-in-england-to-take-second-abortion-pill-at-home-healthcare-leaders-urge/> date accessed 20/02/21.
[121] Ibid.
[122] Chinkin, C. 'Violence Against Women', as in The UN Convention on the Elimination of all Forms of Discrimination Against Women: A Commentary' (OUP, 2013), 469.
[123] LC v Peru (2011) CEDAW/C/50/D/22/2009 (UN CEDAW Committee) para 3.1.

rights permanently after the changes due to coronavirus, would 'punish women [who are] having a legal abortion'.[124] Thus, there seems to be a consensus that allowing abortion pills to be taken at home on a permanent base would provide women with adequate protection from the law that would otherwise amount to unfair treatment, and possibly discrimination on the basis of the outcome of seemingly neutral legislation that is in place.

Adopting the approach to telemedicine for early medical abortions permanently will ensure that the state is providing long term solutions for accessibility issues, for women who have restricted travel, due to disability, social, cultural, and economic issues, thus, ensuring the state's compliance with their obligation to promote and fulfil. The requirement to promote and fulfil is a forward looking approach that incorporates 'short, medium- and long-term policies to combat violence against women'.[125] In *LC v Peru*, the lack of mental health assistance and the delay in being accepted into emergency surgery, clearly breached this obligation as LC suffered degrading treatment as her welfare was not considered.[126] A long-term solution to women who struggle to get abortions due to their vulnerability or disadvantage can be to make EMA being taken at home permanent. This will also ensure an intersectional lens. It has been estimated that one in three women will have an abortion by the age of 45.[127] However, '...medical abortion didn't exist when the 1967 Abortion Act entered the statute books, and the law has consequently been interpreted as requiring both drugs to be taken at a licensed premises.'[128] In contemporary society, this fails to meet the obligations to promote and fulfil through the 'distress' of travelling for an abortion from a clinic, that is possibly preventable through the 'government [using] its executive powers to approve the use of women's homes as premises where early medical abortion could be carried out, as both the Scottish and Welsh governments have done."[129] This has also been enforced through the case of *Mellet v Ireland,* whereby Ireland's incompatibility with international human rights law[130], lead to the concurring opinion of Sarah Cleveland, who found that, the state must adopt measures to achieve the "effective and equal empowerment of women" to ensure there is equal and effective protection against discrimination on the grounds of sex.[131] Therefore, the adaption of the Abortion Act 1967 to comply with the needs of contemporary society would provide a long-term solution by allowing access to abortion from home, whilst also ensuring a consensus within the United

[124] 'Allow women in England to take second abortion pill at home, healthcare leaders urge' (BMJ) <https://www.bmj.com/company/newsroom/allow-women-in-england-to-take-second-abortion-pill-at-home-healthcare-leaders-urge/> date accessed 20/02/21.
[125] Chinkin, C. 'Violence Against Women', as in The UN Convention on the Elimination of all Forms of Discrimination Against Women: A Commentary' (OUP, 2013), 471.
[126] LC v Peru (2011) CEDAW/C/50/D/22/2009 (UN CEDAW Committee), para 3.4.
[127] 'Allow women in England to take second abortion pill at home, healthcare leaders urge' (BMJ) <https://www.bmj.com/company/newsroom/allow-women-in-england-to-take-second-abortion-pill-at-home-healthcare-leaders-urge/> date accessed 20/02/21.
[128] Ibid.
[129] Ibid.
[130] Fiona De Londras, 'Fatal Foetal Abnormality, Irish Constitutional Law, and Mellet v Ireland' (2016) 24 (4) Medical Law Review, 603.
[131] Ibid, 603-604.

Kingdom, alongside the guidelines presented by the World Health Organisation and other international bodies.

With regard for international bodies, the United Nations found that almost 'all deaths from unsafe abortion occur in countries where abortion is severely restricted in law or and/or in practice' and annually '25 million unsafe abortions are estimated to take place'.[132] This illustrates that the accessibility of abortions does not impact the rate of them, but only how they are performed. Under the Human Rights Committee, it is obligatory that "although States parties may adopt measures designed to regulate voluntary terminations of pregnancy, such measures must not result in violation of the right to life of a pregnant woman or girl, or her other rights under the Covenant."[133] A balancing act must be performed between the rights of the foetus and the right of the mother, whilst assessing the accessibility to abortions. Restrictive abortion laws have also been characterised as a form of discrimination and gender-based violence, with the Committee on the Elimination of Discrimination against Women specifying that "it is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women."[134] Further enhanced by the Working Group on discrimination against women who have emphasised the "right of a woman or girl to make autonomous decisions about her own body and reproductive functions is at the very core of her fundamental right to equality and privacy, involving intimate matters of physical and psychological integrity, and is a precondition for the enjoyment of other rights."[135] Another obligation the state falls under is the Committee on Economic, Social and Cultural Rights who explain that states "have a core obligation to ensure, at the very least, minimum essential levels of satisfaction of the right to sexual and reproductive health which includes measures to prevent unsafe abortion."[136] This has been unfortunately shown through a study where 85% of women 'opted to take both drugs at the same time rather than make a return visit to the abortion service, despite knowing that this method was less effective and associated with a higher complication rate.'[137] Thus, as well as a failure of the state's obligation to promote and fulfil, it shows how the state is falling short of international guidelines, emphasising the need for the adaptation of where abortions can take place to perhaps help lower the amount of women who see this ultimatum as an option. This is enhanced by the Committee on the Rights of the Child, who has recommended that "States ensure access to safe abortion and

[132] Office of the High Commissioner, 'INFORMATION SERIES ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: ABORTION' (United Nations Human Rights, 2020) 1 <https://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf> accessed 21/02/2021.
[133] Ibid.
[134] Ibid, 2 (as cited in General Recommendation 24 (1999) on women and health, para. 11.).
[135] Ibid (as cited in Working Group on the issue of discrimination against women in law and in practice (2018), A/HRC/38/46, para. 35.).
[136] Ibid, 3 (as cited in General Comment 22, para. 49).
[137] 'Allow women in England to take second abortion pill at home, healthcare leaders urge' (BMJ) <https://www.bmj.com/company/newsroom/allow-women-in-england-to-take-second-abortion-pill-at-home-healthcare-leaders-urge/> date accessed 20/02/21.

post-abortion care services, irrespective of whether abortion itself is legal."[138] Thus, this corresponds with the state's obligation to promote and fulfil, by engaging with the idea that policies in place to allow abortions is not sufficient if women are being denied access due to certain vulnerabilities or characteristics. Access to abortion must be sufficient to allow all women access, that would be hugely benefitted from the extension of the Abortion Act 1967 to permanently incorporate the at home use of EMA for women.

[138] Office of the High Commissioner, 'INFORMATION SERIES ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: ABORTION' (United Nations Human Rights, 2020) 3 <https://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf> accessed 21/02/2021 (as cited in General Comment 15 on the right of the child to the enjoyment of the highest attainable standard of health (2013) para. 70. See also Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/32/32 (2016), para. 113 (b).).