# Written evidence from MSI Reproductive Choices [WRH0054]

## 1. About MSI Reproductive Choices

1.1 MSI Reproductive Choices (formerly Marie Stopes International) is a global organisation delivering reproductive health services across 37 countries. MSI Reproductive Choices UK has been supporting reproductive health choices for over 40 years. We provide NHS-funded and self-funded abortion and vasectomy care through our network of local clinics all over England, and we run a 24/7 advice line.

## 2 Contraception and women

2.1 Sexual and reproductive healthcare is essential healthcare, and access is particularly important for women's health outcomes.

2.2 The underinvestment in public health since 2015, and specifically in sexual and reproductive healthcare has disproportionately impacted women and girls. Statistically, it is women who will be most affected by pregnancy (financially, physically, and emotionally), women who are most likely to need protection against reproductive coercion, women who are disproportionately responsible for childcare and women who are disproportionately experiencing barriers such as dismissiveness or judgment in relation to their needs and choices.

2.3 According to Public Health England, every £1 invested in contraception saves the Treasury £9 over 10 years[1]. The economic and social benefits are interlinked, such as reducing unintended pregnancies, preventing Sexually Transmitted Infections (STIs), reducing avoidable hospital admissions, allowing families to plan how many children, if any, they want, and easing pressures on the social care sector.

2.4 Since 2015, there have been major cuts to these services. Between 2015/16 and 2020/21, the public health grant that local authorities get for sexual health services was cut by £1billion, or 24%. Investment in sexual and reproductive health services including contraception was cut by nearly 17%. There was a 167% increase in the number of local authorities cutting and closing contraceptive services, with 32 councils making closures and a third of local authorities reducing the sites commissioned to provide contraceptive services[2].

2.5 At the same time there has been a growing demand for sexual and reproductive healthcare services overall as people continue to make smart decisions about consent, safer sex, and their reproductive health[3].

2.6 This has led to worsening gaps in reproductive health outcomes for women and girls, as detailed in the Faculty of Sexual and Reproductive Healthcare (FSRH)'s Hatfield Vision[4], which makes a series of recommendations and has the support of 46 organisations working in the sector.

## 3 Rising demand for abortion care

3.1 Although the most recent abortion statistics have only been published up to the first six months of the previous years (which is partly, although not entirely, due to the backlog caused by the high volume[5]), from these initial figures alone, it's clear that there's an unprecedented rise in demand. National figures show a 17% rise.

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[1] Public Health England, 2018.
[2] Full report (December) - Women's Lives, Women's Rights - Faculty of Sexual and Reproductive Healthcare (fsrh.org)
[3] Breaking point: Securing the future of sexual health services | Local Government Association
[4] FSRH Hatfield Vision July 2022 - Faculty of Sexual and Reproductive Healthcare
[5] 2022 Abortion Statistics for England & Wales: January to June

3.2 MSI Reproductive Choices UK's abortion activity since the start of 2023 has increased by 32% compared with the same time period last year, and vasectomy has increased by 56%. In certain parts of the country, the increase was higher. In central London, MSI Reproductive Choices UK has seen an increase in abortion activity of 134%, and in Yorkshire we saw an increase of 40%.

3.3 These figures are unprecedented and appear to be mainly driven by the lack of access to contraception coupled with the cost-of-living crisis, although there are various contributory interconnected factors, and there is rarely on single reason why somebody has an abortion or a vasectomy.

## 4. Reproductive healthcare and the cost-of-living crisis

4.1 As the All-Party Parliamentary Group (APPG) on Sexual and Reproductive Health explained in its Access to Contraception Report[6], the National Survey of Sexual Attitudes and Lifestyles (NATSAL) reports that "45% of pregnancies and one third of births in England are unplanned or associated with feelings of ambivalence."

4.2 The lack of access to contraception disproportionately impacts the people in the most deprived parts of the country, thereby exacerbating existing health inequalities. Those on the lowest incomes in the country are not only concerned about the costs of pregnancy and parenting; they are often more likely to experience an unintended pregnancy in the first place.

4.3 This has been further exacerbated by the cost-of-living crisis and growing workforce precarity, with more and more people unable to afford the costs associated with being pregnant, let alone the costs of having children (or having more children if they are already parents). These pressures have certainly not been helped by the ongoing impact of COVID-19 on services and workforce, as set out in the APPG's updated version of its report to account for the impact of the pandemic, and the progress report which assesses the extent to which the issues identified have been addressed.

4.4 Many unplanned pregnancies are, of course, a positive occurrence but with 45% met with "ambivalence" even before the cost-of-living crisis, it's unsurprising that spiralling costs for food, clothes, rent, mortgages, childcare and travel are all contributing to a greater demand for abortion care.

## 5. Reproductive healthcare and gender-based violence

5.1 The stress and instability of the last three years has created all sorts of indirect ripple effects into people's lives. According to the Local Government Association, there was a 795% rise in domestic abuse between 2019 and 2021. While that was largely connected with lockdown, the longer-term consequences of the COVID period (including economic instability, mental health issues, housing insecurity, or alcohol and substance misuse) continue to indirectly contribute to circumstances that increase the risk of domestic abuse and make it more difficult for women in particular to leave abusive partners.

5.2 Pregnancy is one of the most dangerous times for those in abusive relationships. Reproductive coercion (for example, forced pregnancy or interfering with contraception) is a common means of control[7]. It can be used to make it harder for women to leave relationships or as an excuse to control a partner's diet, health choices, and general bodily autonomy.

5.3 Reproductive choice is essential for giving control and autonomy in these circumstances. That doesn't just mean being legally able to have an abortion; it means choice of contraception, choice of abortion method, choice of location, and as far as is practical, choice about timing. In reality, this means the choice to take both abortion pills at home (which MSI Reproductive Choices UK successfully advocated for last year together with partners) and a choice of provider.

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[6] APPG SRH publishes progress update on Access to Contraception Inquiry report - Faculty of Sexual and Reproductive Healthcare (fsrh.org)
[7] How to recognise and respond to reproductive coercion | The BMJ

## 6. Improving and investing in abortion care

### 6.1 Home access

6.1.1 Since COVID-19, it has been legal to take both mifepristone and misoprostol (the medicines which complete a medical abortion) at home. Prior to the pandemic, it was only legal to take the second pill at home. Following a vote in Parliament, this option was made permanently available across England and Wales.

6.1.2 Peer-reviewed evidence, including the largest ever abortion study of over 50,000 procedures[8], has repeatedly found early medical abortion at home to be effective, safe, and to be preferred by a majority of women. In one study, 89% of women who used the service said they would prefer home access should they ever need abortion care again[9].

6.1.3 The at-home service (also known as early medical abortion at home, at-home abortion care, and telemedicine) has allowed women the option of accessing abortion care in the privacy and comfort of their own home. Qualified health advisers can provide the pre-abortion consultation by phone, can deliver abortion medication in discrete packaging to the recipient's usual place of residence, and/or can allow collection from a nearby clinic or centre.

6.1.4 During the abortion care pathway, clinicians (and, where appropriate, safeguarding professionals) make an informed judgement about whether an in-person appointment is advisable, and if necessary, encourage or insist on in-person attendance. These pathways are designed in line with longstanding and widely recognised regulations, guidance, and legal frameworks and are accountable to the Care Quality Commission (CQC), NHS commissioners, NHS England, the Department of Health and Social Care (DHSC) and, of course, the law.

6.1.5 Those who are unable to access a clinic in person (for example, due to domestic abuse, disability, privacy preferences, or caring and work commitments) can now access safe, legal, regulated abortion care provided through the NHS, instead of being forced to end a pregnancy through alternative means. A peer-reviewed paper published in the British Medical Journal (BMJ) shows that the purchase of online abortion medicines from unregulated providers dropped to almost zero since the legal availability of telemedicine[10].

## 7. Investment, improvements, and choice

7.1 Abortion providers are regularly evaluating and improving services to ensure compliance with the highest standards. This year MSI Reproductive Choices UK's Manchester clinic became the first ever abortion service to be rated 'outstanding' by the CQC.

7.2 Yet, in addition to the underinvestment that public health has seen, abortion services have been unfairly funded (and often poorly commissioned) for even longer. NHS commissioners often lack accountability and transparency in their funding decisions, paying independent non-profit abortion providers well under the NHS tariff based on calculations from over a decade ago. Technological developments, digital access, effective safeguarding, and NHS pathways for those with complex needs are all overlooked when funding calculations are made, leaving abortion providers to absorb these costs in order to deliver the high-quality care that women deserve.

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[8] Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study, British Journal of Obstetrics and Gynaecology

[9] Telemedicine medical abortion at home under 12 weeks' gestation: a prospective observational cohort study during the COVID-19 pandemic, British Medical Journal

[10] Demand for self-managed online telemedicine abortion in eight European countries during the COVID-19 pandemic: a regression discontinuity analysis

7.3 There has been progress from NHS England on updating the payment models but there remains a lack of accountability in terms of commissioners implemented the new recommended approach, which risks causing a geographical inequity due to the priorities of individual Integrated Care Boards (ICBs).

7.4 A standard service specification has been developed by the Royal College of Obstetricians and Gynaecologists (RCOG)[11]; it should be endorsed as best practice by NHS England and commissioners should be held to account regarding the extent to which their service specifications are aligned with this standard.

7.5 Commissioners should be held accountable for their calculations and each Integrated Care Board should have a named role responsible for reproductive health, including abortion care. This could be a women's health lead or champion, or it could sit within another brief, but it should be explicit and intentional that reproductive healthcare, including abortion commissioning, sits within their remit.

7.6 Scrutiny mechanisms should support this; for example, local authority scrutiny committees should be encouraged and supported to hold commissioners to account on their management of abortion services. Individuals holding these roles, whether they sit within commissioning bodies or within local authorities should be expected to hold no prejudices to or opposition to abortion, and ideally would be supported in undertaking Values Clarification training to understand the common forms of stigma and misinformation, and how these misunderstandings about abortion can create barriers to treatment and negatively impact health outcomes.

## Choice

With abortion care, choice is essential. Yet the principle of 'patient choice,' enforced so rigorously in the context of maternity care and other services, is ambiguous at best in terms of its application to abortion services. Some commissioners have declined to reimburse independent non-profit providers for treatment offered to women where there is a serious need, on the basis that the women in question have no right to choose a provider other than the one commissioned for their local area. This has been upheld by NHS England, which means that providers are forced to turn women away from essential services, as providing them for free is not sustainable or safe.

Choice is a vital part of accessing sensitive, specialist services like abortion. There are many reasons why choice of provider is important. For example, a woman might know an individual working at one provider organisation, may know people who live close to the sole contracted provider's premises, or may prefer a particular type of care, such as surgery rather than abortion pills, or anaesthetic over conscious sedation[12] which is not offered by every provider.

The principle of patient choice and the rights associated with this principle as set out in the NHS Constitution[13] and NHS Choice Framework[14] should be explicitly and intentionally stated as applicable to abortion care, so that anyone seeking an abortion has the right to choose the provider and the type of service which best meets their individual circumstances.

Choice does not only apply to abortion care. Vasectomy is currently underfunded and many ICBs do not commission adequate provision. Self-referral should be consistently available across the country and the

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[11] National Service Specification for Abortion Care in the NHS (rcog.org.uk)

[12] NICE Guidance currently recommends conscious sedation, but MSI Reproductive Choices UK holds that everyone has different preferences, and particularly for sensitive cases, such as a wanted pregnancy terminated out of medical necessity, the risk of a vulnerable person consciously experiencing any of the abortion against their wishes is serious enough that the option of general anaesthetic should be offered. Not all providers offer general anaesthetic; we believe the person having the abortion should have the right to make this choice upheld by the NHS Choice Framework.

[13] The NHS Constitution for England - GOV.UK (www.gov.uk)

[14] The NHS Choice Framework: what choices are available to me in the NHS? - GOV.UK (www.gov.uk)

funding model for vasectomy procedures should be recalculated based on the best available evidence so that provision can match the growing demand.

While vasectomy is a service primarily used by men, the lengthy waiting times, inadequate access, and myths and stigma surrounding the service all have a negative impact on women and the services primarily used by women. Research shows that women disproportionately do the work of planning, buying, and using contraception, which includes experiencing the side effects. Men should be supported to take more responsibility for contraception and choose vasectomy where appropriate for their needs. Reproductive healthcare policy should be looked at holistically; silos between the services mostly used by men and services mostly used by women contribute to a vision of reproductive healthcare whereby women continue to be disproportionately responsible while men are prevented from choosing the options that best suit their needs.

## Young people and reproductive health

Girls and young women have specific sexual and reproductive healthcare needs, which often differ from the needs of adult women.

Privacy and consent are extremely important for young women. The principle of Gillick competence is well-established and is absolutely critical for young women to access the right healthcare for their needs. There are dangers for women and girls in allowing the principle of Gillick competence to be undermined in relation to any area of healthcare, as this would have serious implications for the right to access abortion and contraception, including contraceptive methods used as treatment for non-sexual medical conditions.

Misinformation about sexual health, consent, bodily autonomy, and reproductive rights is a major risk for young people, especially online. A key tool in ensuring young people, especially young women, are protected from false information is comprehensive sex and relationships in schools. It is essential that the sex and relationships curriculum is comprehensive, evidence-based, and inclusive so that young people are able to trust and relate to the information they are given in schools.

## Abortion law reform

In Great Britain, abortion currently sits within criminal law, despite Westminster voting to decriminalise abortion in Northern Ireland. There is no clinical or ethical reason for this. Abortion is criminalised under sections 58, 59, and 60 of the Offences Against the Persons Act 1861 and the Infant Life Preservation Act 1929. These laws are unnecessarily proscriptive and are not rooted in medical evidence. They limit reasons for choosing abortion, add bureaucratic barriers for a health service facing ever-increasing pressures, and restrict the ability of abortion providers to deliver flexible care in line with modern clinical standards. These laws were written before medical abortion (pills) was available, and before medicine operated on the principle of informed consent (whereby clinicians discuss possible options with the person they treat, allowing them to make their own decisions) as it does today.

The World Health Organisation (WHO) recommend that abortion be decriminalised, as does the British Medical Association (BMA) and the Royal College of Obstetricians and Gynaecologists (RCOG).

Regulations pertaining to healthcare, medicines management, safeguarding or consent need not change for abortion to be decriminalised. For example, the Human Medicines Regulations 2012 establishes the circumstances under which prescription-only medicines can be obtained or distributed. These regulations and laws are not part of the Abortion Act 1967 or the Infant Life (Preservation) Act 1929, and therefore decriminalising abortion would not affect these existing protections, regulations, and laws.

## Summary (recommendations):

- Abortion should be removed from criminal law. In practice, this means repealing Sections 58, 59, and 60 of the Offences Against the Persons Act 1861 and repealing the Infant Life Preservation

Act 1929. Abortion should be regulated in the same way as any other comparable healthcare, as per the model in Canada.

- The legal option of Early Medical Abortion at home should be recognised as essential for delivering high-quality services which meet safeguarding best practice.
- The Abortion National Service Specification as developed by RCOG should be endorsed by NHS England and commissioners should be held accountable for the extent to which their service specifications are aligned with this standard.
- The principles of 'patient choice' as set out within the NHS Constitution and the NHS Choice Framework should be explicitly applicable to abortion care. Commissioners should be obliged to pay providers for abortion care which meets demand outside the contracted agreements (Non-Contractual Activity), including when demand is driven by individual preference not clinical necessity.
- The principle of choice should include vasectomy where appropriate. Self-referral for vasectomy should be supported by all commissioners, instead of the current postcode lottery. Vasectomy funding models should be reviewed and updated where needed.
- Every Integrated Care Board should have a named individual responsible for reproductive healthcare, including abortion. This may be a women's health champion or women's health lead, but it should be explicit that the brief includes reproductive healthcare. The named lead should be encouraged to complete Values Clarification training to ensure the complexity of abortion care is fully understood.
- Local scrutiny mechanisms (such as local authority Overview and Scrutiny Committees) should hold commissioners accountable over their provision and funding of abortion care.
- While there is scope for exploring the ways in which abortion care can be integrated into wider health systems or Women's Health Hubs, the essential role of specialist providers must be recognised within these models.
- Abortion should be part of the standard curriculum for healthcare professionals. The sensitivities and complexities of abortion care must be understood by any individual or organisation holding responsibility for provision, delivery, or evaluating outcomes of abortion services.
- Public health investment in sexual and reproductive healthcare should be restored to pre-2015 levels, with a commitment to increase investment to match changing needs and targeting the areas most impacted by the near decade of cuts.
- Gillick competence and the Fraser guidelines should be protected and defended.
- Sex and relationships education should be comprehensive, evidence-based, and inclusive, designed with active participation from young people themselves.

***September 2023***