Written evidence from MIS Reproductive Choices UK [RCW0053]

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, contraception, and vasectomy care through our network of local clinics all over England, and we run a 24/7 advice line.

2. Reproductive healthcare and the cost-of-living crisis

2.1 National figures for 2022 (which are incomplete due to a backlog) show a 17% rise in abortion in England and Wales[1]. As a leading abortion provider MSI Reproductive Choices UK has seen an even bigger rise. For example, the first period in 2023 saw an increase of 32% compared with the same time period in 2022, and vasectomy increased by 56%. In certain parts of the country, the increase was higher. In central London, MSI Reproductive Choices UK saw an increase in abortion activity of 134%, and in Yorkshire we saw an increase of 40%. We understand that NHS Trusts and other providers have seen a similar pattern.

2.2 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.

2.3 As the All-Party Parliamentary Group (APPG) on Sexual and Reproductive Health explained in its Access to Contraception Report[2], 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."

2.4 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. 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.

2.5 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.

2.6 Many unplanned pregnancies are 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.

2.7 Women are disproportionately likely to be responsible for childcare and for other aspects of parenting, which means the implications of these rising costs are experienced significantly by women.

2.8 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

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[1] 2022 Abortion Statistics for England & Wales: January to June

[2] APPG SRH publishes progress update on Access to Contraception Inquiry report - Faculty of Sexual and Reproductive Healthcare (fsrh.org)

between 2019 and 2021[3]. 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.

2.9 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[4]. 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. Reproductive choice is essential for giving control and autonomy in these circumstances.

2.10 As a result of telemedicine being legally available, 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. Previously, they were forced to end a pregnancy through alternative means, which meant they would not have access to counselling, onward referrals (such as to community domestic abuse services), and other support built into the service pathways.

2.11 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[5]. Telemedicine is preferred by a majority of women in general but in addition to this, it should be acknowledged that this option has a particular benefit for women most impacted by the cost-of-living crisis.

3. Abortion law reform

3.1 With abortion in Britain still sitting within criminal law[6], women's choices about their own pregnancies risk criminal prosecution or even prison. This can never be in the public interest. In the extremely rare cases where women end their own pregnancies outside the parameters of the Abortion Act 1967 (for example, without signed forms from two doctors to confirm that there is a legally acceptable medical justification), the women pose no danger to wider society and need compassion, support, and advice, not prosecution.

3.2 Since 2018, there has been a rising number of police investigations into unexplained pregnancy losses, where people are suspected of ending their own pregnancies outside the law. There are many factors driving this, including a greater awareness of medical abortion (i.e., abortion using pills rather than a surgical procedure), but we do regularly hear from women that the cost-of-living crisis is putting them in extremely difficult situations where they are forced to make complicated decisions about their reproductive futures and the size of their families – sometimes at a much later stage in the pregnancy than they would like.

3.3 The financial pressures and the access to contraception challenges described above mean that there is a particular risk for women in the toughest economic circumstances in terms of the risk of criminalisation under Britain outdated abortion laws. For example, financial difficulties make it harder to leave an abusive partner, which can be a factor in ending a pregnancy outside the law. Challenges with transport or

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[3] Breaking point: Securing the future of sexual health services | Local Government Association
[4] How to recognise and respond to reproductive coercion | The BMJ
[5] Demand for self-managed online telemedicine abortion in eight European countries during the COVID-19 pandemic: a regression discontinuity analysis
[6] MSI UK Position Paper 2022: decriminalisation of abortion care in Great Britain

3.4 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).

4. Home access and choice

4.1 Women hit hardest by the cost-of-living crisis can experience disproportionate challenges with accessing healthcare through formal, regulated systems. For example, women on zero hours contracts or with inflexible employment are less likely to be able to attend a clinic in person and therefore more likely to order pills online.

4.2 By voting last year[7] to make telemedicine permanently legal for abortion care, Parliament has allowed these women to access NHS-funded abortion care through a regulated provider with support mechanisms such as counselling and community referrals (such as to local domestic abuse, debt advice, or mental health services). It is vital for all women that telemedicine is maintained and recognised as an essential part of reproductive healthcare, but especially for the women most impacted by the cost-of-living crisis.

5. Summary of recommendations

5.1 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.

5.2 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.

5.3 The legal option of Early Medical Abortion at home should continue to be recognised as essential for delivering high-quality services which meet safeguarding best practice.

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[7] Health and Care Act 2022 (legislation.gov.uk)