

Early medical abortion: best practice now lawful in Scotland and Wales but not available to women in England

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INTRODUCTION

Abortion legislation in the British Isles is fragmented and no longer fit for purpose. In Scotland, recent changes in the application of the 1967 Abortion Act have improved care for women opting for early medical abortion (EMA), bringing medical practice into line with international standards. Similar changes are planned for Wales, and new regulations are currently under review in the Isle of Man parliament. Following the emphatic result of the referendum in the Republic of Ireland to permit abortion, it is likely that safe, evidence-based, woman-centred regimens will be available there soon.¹ Despite women making up 51% of the population, the governments in England and Northern Ireland have yet to show the same compassion for women's health and safety.

Abortion is common. Worldwide it is estimated that 25% of all pregnancies end in abortion.² In England and Wales, 2.5% of all women aged 20–29 years have an abortion each year,³ while an estimated one in three women will have an abortion by the age of 45 years.⁴ The majority of these occur early in pregnancy when an EMA is most effective, and this is what most women choose. Of the 146 912 women in Great Britain who had an abortion before 9 weeks' gestation in 2016, 75% of those living in England and Wales and 89% of those living in Scotland chose a medical abortion.^{3 5}

The most effective regimen, mifepristone (200mg oral) followed by misoprostol (800µg vaginal, sublingual or buccal), is safe and well-tolerated by women, but is most effective when there is an interval of 24–48 hours between the

two drugs.⁴ This raises the question as to where the second dose is administered. In Scotland, and soon in Wales, misoprostol can be taken in the woman's home, but in England it must be administered within a licensed hospital or clinic.

HOME USE OF ABORTIFACIENTS

There is strong evidence that using these drugs at home rather than in hospital is safe, preferred by women, and does not increase abortion rates.^{6 7} Women's preference for home administration is easy to grasp: it allows for greater privacy, better control over timing, and better emotional support from family, while also reducing the burden on healthcare facilities. Misoprostol can cause an abortion to start within an hour, resulting in pain and heavy bleeding on the journey home from hospital – an unacceptably distressing experience.⁸ While women who are miscarrying are offered the choice of taking misoprostol in the privacy of their own home,⁹ the same dignity is not currently accorded women in England who are having an EMA.

Home use is common in most parts of the world where abortion is legal, and it is not surprising that it is recommended by the WHO and in many national guidelines.^{4 7 10–12} Studies from many countries including Sweden, Norway, Tunisia, USA, France, Vietnam, Mexico and the UK have shown women find home use highly acceptable, with 95% preferring home use to hospital.^{13 14} Contrary to fears which are sometimes expressed by those opposing abortion, the rates of abortion do not increase in countries when effective medical regimens are approved.⁷ Rather, it is the proportion that opt for



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medical abortion over surgery that increases, with women in rural areas benefiting from improved access to abortion care.

The problem in England arises from the application of the 1967 Abortion Act. In the year after celebrating the 50th anniversary of the Act in the UK and appreciating how women's lives have been transformed by safe abortion,¹⁵ it comes as a bittersweet realisation that those very provisions that removed the horrors of illegal 'backstreet' abortions are now preventing the safe home use of drugs for EMA in England. When the Abortion Act was enacted, EMA with mifepristone and misoprostol did not exist and therefore the Act makes no provision for this method. Consequently it has been interpreted in UK law that both drugs should be administered on licensed premises. This obligation to return to the abortion service (often a hospital or remote clinic) for a second visit impacts many women who struggle with repeated time off work, childcare, transport difficulties or distance from the abortion service.¹⁶ Furthermore, it selectively disadvantages the most vulnerable – those who are deprived, live in rural areas or have dependents.

SIMULTANEOUS REGIMENS: AN ENGLISH COMPROMISE

The degree of difficulty that this second visit poses for many women is reflected in a recent study using data from one of the UK's largest abortion providers, reporting on the experience of over 28 000 women having EMA over a year.¹⁷ The authors found 85% chose simultaneous regimens despite knowing of their lower efficacy and higher complication rates when compared with returning for a second visit, demonstrating how much of a barrier access is for many women. The simultaneous regimen resulted in an additional 2.6% of women needing surgery, with more than twice as many failures compared with the interval regimen (ongoing pregnancy rate 2.4% vs 0.9%, simultaneous versus interval regimen). For every 38 women treated with simultaneous medication, one additional woman suffered a complication that required surgery as compared with those taking the medications at an interval. With only 15% choosing or able to return for a second visit, the implication is that many women required additional, preventable surgery and anaesthesia as a direct consequence of the government's current interpretation of the Abortion Act.

Another argument for offering simultaneous regimens is that there is a longer interval before bleeding starts,¹⁸ which should reduce the risk of bleeding, cramping and an abortion occurring while travelling or waiting for public transport. Women from rural communities, for example in Cornwall, have little choice but to opt for same-day treatment because of the difficulties they have in accessing services and the long travel times they face, but in doing so they have to accept the increased risk of complications and treatment failure. If women were able to take misoprostol at

home 24–48 hours after mifepristone, the failure rate and need for surgery would be significantly reduced and the distress of bleeding, cramping and aborting a pregnancy in public while travelling would be almost eliminated.

SCOTLAND

On 26 October 2017 the Chief Medical Officer Scotland issued a letter 'Abortion: improvement to existing services' to confirm immediate approval for misoprostol to be taken in a patient's home under defined circumstances.¹⁹ The letter was accompanied by a national guidance document on home use of misoprostol in EMA (up to 9+6 weeks) which had been produced by the Scottish Abortion Care Providers network. The letter and guideline demonstrated that both the abortion care providers and policymakers had the same aim: to improve the care for women having an abortion. Central to this change had been a focus on listening to what women said, in particular accounts captured as part of qualitative research from women undergoing EMA at home throughout Scotland.^{8 20} The experiences described by women – the difficulties they faced in having to make an additional clinic visit simply for misoprostol, then travelling long distances and bleeding while on the journey home after misoprostol – strengthened the case for change.

Home use of misoprostol in Scotland is relatively new. The larger abortion services in Scotland report widescale uptake of home use of misoprostol among women and that it is highly appreciated with no negative impact on services (S Cameron, personal communication, 2018). Rather, having fewer clinic visits enables services to rationalise and optimise staffing levels, freeing staff to deploy in other parts of the service.

WALES

On 17 April 2018 the Welsh Assembly Cabinet Secretary for Health and Social Services announced that he had instructed officials to start work immediately to look at how the framework of the Abortion Act 1967 could be amended to allow a woman's home to be a legal place for abortion. This policy change means that as in Scotland, only one visit to the licensed clinic will be necessary for Welsh women. This decision followed discussions which took place during the Sexual Health Review by Public Health Wales in the Autumn of 2017, chaired by the Chief Medical Officer for Wales. The programme board agreed that the proposal was a cost-neutral way of reducing variations in abortion care and was a natural fit with the Welsh Government's Prudent Healthcare initiative (<http://www.prudenthealthcare.org.uk/>).

CONCLUSIONS

In 2007, a comprehensive parliamentary report stated that government's failure to permit home use of

Box 1 Summary of key points.

- ▶ Early medical abortion at home is safe, effective, preferred by women and is recommended by the WHO and many national guidelines, but requires a 24–48-hour interval between mifepristone and misoprostol doses for most effective treatment.
- ▶ English practice is out of step with other countries including Scotland and soon Wales, by requiring women to attend licensed premises (hospital or clinic) for the administration of both drugs on site. Access to remote licensed premises is a barrier for many women, particularly vulnerable groups, and they face the danger of the abortion occurring on their journey home – an unacceptably distressing experience.
- ▶ When offered an informed choice, 85% of women chose a lower efficacy single-visit regimen instead of having to return for a second visit, although this resulted in one additional woman suffering a complication that required surgery for every 38 women treated with simultaneous medication.
- ▶ The Secretary of State for Health (England) has the power to ensure all women in Great Britain have access to the same international standards of best practice by exercising his powers under s.1(3A) of the Abortion Act 1967. We urge him immediately to follow the lead of his Scottish and Welsh colleagues to grant the same compassion, respect and dignity to over 100 000 women in England every year.

misoprostol in England was not owing to “concerns over safety, effectiveness or acceptability”.²¹ The implication was that this was a political, and not a clinical, decision. It recommended that home use be authorised. This would not require a change in the existing law – it simply needs government to use its executive power under s.1 (3A) of the Abortion Act 1967 to approve women’s own homes as a class of places where EMA may be lawfully carried out, as is the case in Scotland and will soon be in Wales (see Box 1).

We strongly encourage the UK Government to follow the recommendation of this House of Commons report and the lead of many other countries across the world. Specifically, we urge the Secretary of State for Health 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. There can be no justification not to act unless the aim is to punish women having a legal abortion. The time for action is now.

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