Executive Summary of VfJUK Report:

DIY Abortions up to 10 Weeks:

What are the Legal and Medical Issues?

"Home use of both pills for early medical abortion up to 10 weeks gestation"

VfJUK's full report can be read here.

Executive Summary

Introduction

In the wake of the pandemic, temporary legislation was passed (2020 Approval), allowing women for the first time to self-administer two abortion drugs (mifepristone and misoprostol) at home. Covering early medical abortions (EMAs) up to 10 weeks gestation, there's no requirement of a physical examination. The pills are sent by post, following a remote consultation. The Government is now consulting on whether to make these measures permanent, to repeal them immediately, or for them to remain lawful for the minimum two-year duration of provisions contained in the Coronavirus Act 2020.

The Law

The Abortion Act 1967 sets out the lawful conditions for abortion. This includes a requirement that two registered medical practitioners (RMPs) authorize the abortion in good faith. Abortions can only be done at registered and approved locations like hospitals and clinics; private residences are not included. Further changes to abortion law were made in 1990, giving the Health Secretary a power to issue regulations, widening the types of locations at which abortions could be done. The change was driven by the prospect that drugs like mifepristone, would one day be licensed. The then Health Secretary rejected fears that the new powers were a "paving measure" for home abortions, assuring parliament that this pill "would be administered only in closely regulated circumstances" under supervision of an RMP.

While the 1967 Act requires the RMP to perform the abortion, the courts have interpreted this to allow RMPs involvement to be supervisory. RMPs must remain in

authority and take responsibility throughout the process, even while nurses and midwives administer the abortion drugs. An RMP need not see or examine the woman themselves but they must ensure they have considered sufficient information, ensuring the abortion meets the relevant statutory ground.

The Offenses Against the Person Act 1861 makes it a criminal offense for a woman to procure her own abortion, and for any person intentionally to assist a woman in the administering of a substance that procures an abortion. The 2020 Approval breaches these two requirements, falling foul of the criminal law.

Abortion providers must receive written approval from the Health Secretary to have their premises recognised as a lawful class of place for abortions. Abortion is a regulated activity. People carrying out a regulated activity without appropriate registration commit an offense. Given the rigorous approach to the regulated activity of abortion, allowing women to administer both abortifacient drugs at home, disregards essential legal and medical safeguards.

Changes to 'Class of Place'

In 2018, the rules for EMAs recognised a woman's home for those who chose this option. This was only for the purpose of her self-administering the second pill. Women would continue to attend a clinic where the first pill was administered, and relevant tests were conducted.

In March 2020, the rules changed again, doing away with the need for physical examinations, blood tests and an ultrasound scan to determine the gestational age of the foetus. Under the 2018 rules, while some of the assessment may have begun by phone, it was followed by a visit to the abortion provider, where the woman's medical history was taken, verified and then assessed for eligibility.

One of the purposes of the 1967 Act was to "ensure that the abortion is carried out with all proper skill and in hygienic conditions." Residential settings cannot be expected to comply with the hygiene standards of clinics or hospitals.

Days before the government caved into lobbyist pressures, the Health Minister strongly rejected the need for change, citing safety concerns, including the protection of women in abusive relationships who may be coerced into an abortion. He also paid regard to the existing checks and balances and established arrangements in place for RMPs to certify and perform abortions. Any change, he explained, lacked widespread parliamentary support, and it was not right to rush through such a sensitive measure without adequate scrutiny.

Risk of Coercion

Research shows that intimate partner violence is a strong risk factor in abortion around the world. Remote consultations make it difficult to know if a woman is acting freely or under coercion. If seen in person and alone, she is more likely to feel able to disclose issues of domestic violence, intimidation or manipulation. The Health Minister said at the time that the Government believed it was an "essential safeguard" for women to attend a clinic, thus ensuring the opportunity to be seen alone.

Evidence of Multiple Legal Abuses & Medical Risks

Evidence from an undercover investigation exposed a raft of serious safety concerns and blatant legal abuses of the telemedicine regime. In a report produced by a former Director of Marie Stopes International, it found that "Abortion providers are operating as if abortion on-demand for any reason is legal." Women had abortion pills sent to them, having provided false identities and conflicting information about their last menstrual period. Reliance on a woman's self-assessment, the report continued, meant a woman has been "co-opted as an essential member of the multidisciplinary team" working for the RMP, and "providing important clinical information necessary for the correct [legal] certification" of an abortion.

The report found that women could keep their abortion confidential even from their GP; there were no follow-up care calls after the abortion pills were sent out; the RMP cannot know if the woman, for whom the pills are prescribed, is actually pregnant and, if she is, whether it falls within the required gestational limit; the RMP cannot ensure she takes the drugs at the prescribed times, thus safely completing the abortion. The 'good faith' requirement of an RMP authorising an abortion no longer depended, the report concludes, upon a direct, supervisory relationship between the RMP and the multidisciplinary team, but on "unsubstantiated information" provided by a woman, so the right boxes are ticked.

The report considers guidance published by NICE, often cited as recommending the use of telemedicine for abortion assessment. The report explains the guidance is actually about making it easier and quicker for women to access the service, so that the phone call is only part of the consultation process. While the NICE recommendation for a medical abortion is that it can be done without a certifying ultrasound scan to determine gestational age, this is in the context of doing an hCG blood test. Therefore, a clinic appointment is needed.

The report warns against the use of codeine phosphate, pain management tablets sent out with the abortion drugs. This drug is addictive, liable to abuse, is rarely prescribed

alone and is unsafe for pain relief. Women seeking medication for menstrual bleeding at a pharmacy won't routinely be offered this class B drug as a first resort, but advised to take pain relief like ibuprofen or paracetamol. The report cites NICE guidance that advises ibuprofen to be taken for heavy bleeding, or if found to be harmful, paracetamol is offered as an alternative. Women who featured in the report's findings were not given sufficient guidance on dosage and timing of self-administered doses of the pain relief tablets, and the report warns about vulnerable women overdosing, resulting in conditions including chest pain.

There are concerns about ectopic pregnancies, which don't always have symptoms. Ectopic pregnancies are serious and may be fatal, if left untreated. Remote consultation can easily miss the signs but tests can provide confirmation of diagnosis. There are well-founded concerns about the risks of post-abortion mental health outcomes.

Medical risks

With telemedicine abortions, there are medical risks: antibiotics are not provided that would reduce infection risks and the later development of Pelvic Inflammatory Disease, putting women at greater risk of subsequent infertility. The RCOG recommends screening for STIs for women having abortions but, again, telemedicine prevents this from happening. There are also risks of sepsis and haemorrhage.

Questions asked include: "How does a doctor ensure that the woman actually takes the medical abortion tablets at the right time and in the right way, rather than someone else – perhaps a woman at a later stage of pregnancy?"

The Royal College of Obstetricians and Gynaecologists states that the interval between both abortion drugs must be 24-48 hours. If this timing is missed, the abortion may be incomplete, and there's an increased likelihood of bleeding if the interval is delayed. Likely symptoms to be experienced both during and after the abortion are menstrual-like cramps, pain and bleeding.

The authoritative electronic medicines compendium (EMC) advises that in emergencies, a "patient has access to medical facilities equipped to provide surgical treatment for incomplete abortion, or emergency blood transfusion or resuscitation" – telemedicine doesn't allow for these safeguards. Neither does it cater to cases of failed abortions, where the EMC advises mandatory follow-up visits within 14-21 days to verify via tests and scans that the abortion is complete, and that vaginal bleeding has ceased or reduced. Patients must be informed about the possibility of surgery in cases of a failed abortion. The EMC states: "Bleeding is not in any way a proof of

termination of pregnancy as it occurs also in most cases of failure." A strong warning is issued on the administration of both abortion drugs: "This product SHOULD NEVER be prescribed" in a range of situations that include a "pregnancy not confirmed by gynaecological examination, ultrasound scan or biological tests."

These medical dangers faced by women haven't been accounted for in the 2020 rules. Previously, when women had much or all of their medical abortion at a registered location, this provided essential safeguards against adverse medical outcomes. Women now face increased medical risks on a variety of fronts. Attempts to make permanent these temporary provisions must be resisted.

Further to the report, questions are raised about the as yet unknown full mental health impact on women, who do their own abortion at home in their bathroom. Popular public health messages appear to claim there's no adverse mental health outcomes for women undergoing abortion, but it's not risk-free. The scientific literature doesn't entirely deny these post-abortion risks, but they're treated as minimal, or more likely for certain at-risk groups. While a global consensus is yet to be reached, a growing and credible body of scientific evidence means it's misleading for women to be told that abortion poses no risk to their future mental health.

The new rules allowing women to self-administer two abortion pills at home brings numerous medical risks and harms to their health. VfJUK is calling on the government to immediately end this set-up. Women must no longer be denied the right to be seen and examined in person to certify relevant aspects of the pregnancy, thus having more regard for their medical safety.