Home use of misoprostol

Improving the provision of Early Medical Abortions

Background

What is an Early Medical Abortion?

Early medical abortion (EMA) is a non-invasive, non-surgical method of termination of pregnancy up to 70 days (10 weeks) gestation, using a combination of two drugs: mifepristone and misoprostol. Mifepristone is a synthetic steroid which blocks the hormone progesterone. Without this hormone, the lining of the uterus breaks down and the pregnancy ceases to be sustainable. Misoprostol is a prostaglandin, which causes the uterus to contract and expel the pregnancy.

Medical abortions are possible at any time during pregnancy, but post-10 weeks require additional clinical support and thus are not covered in the calls for home use of misoprostol.

EMAs in Great Britain

EMAs are the most common type of abortion procedure. Of the 198,422 abortions performed in England, Scotland, and Wales in 2016, 58% of them (115,450) were Early Medical Abortions.

This reflects a movement over time towards medical rather than surgical procedures, and an increase in the proportion of procedures that take place at the earliest stages of pregnancy – 80% of abortions now take place before the 10th week of pregnancy. The proportion of medical abortions is significantly higher in Scotland and Wales than it is in England.

Safety of EMA

EMA is very safe. No medical procedure is risk free, but the risks of early medical abortion are extremely small and considerably less than the risks of continuing a pregnancy to term. EMA can often be carried out as soon as a pregnancy is confirmed, and the earlier an abortion can be performed the lower the chance of any complications.

EMA also avoids any anaesthetic risk that surgical procedures may pose, and any risk of infection is minimised by providing all women with prophylactic antibiotics. Rare complications that can occur include continuing pregnancy and incomplete abortion, which can be managed with either a further dose of misoprostol or a surgical evacuation.

All women leave the clinic with an appropriate supply of pain relief, antibiotics, and detailed advice as to what to expect, and what might indicate a problem. They have access to a specialist 24 hour, seven days a week helpline and we ensure that there is the facility to attend for urgent medical treatment, if needed.

Current procedure

What happens

A woman presenting at bpas for an Early Medical Abortion usually has two options – either to take both medicines (mifepristone and misoprostol) on the same day, or to leave up to 72 hours between administration and return to the clinic on another day. Both of these methods are safe, but taking the pills on separate days is a more effective method of termination (less than 1% failure rate, compared to a 2% failure rate for taking both pills on the same day). The side effects of the medication are also reduced when the pills are taken on different days – for instance half the chance of developing nausea, 1/3 of the chance of vomiting, and 1/4 of the chance of dizziness.

Problems with the current procedure

Currently the Department of Health defines 'treatment for the termination of pregnancy' in an approved setting as set out in the Abortion Act 1967 as meaning that both the prescribing and administration of abortion drugs must take place in a hospital or licensed clinic. Although women can choose to remain in clinics to pass their pregnancy, the vast majority do not. A study of BPAS clients in 2010 found that most women who have opted for early medical abortion (86%) would rather go home to complete an EMA than remain in a clinical setting as the process can take time, and most would rather be in the comfort and privacy of their own home when they are bleeding and cramping.

Current rules, then, mean that women must take the medication that will start their miscarriage before they begin to travel home. At this point, the clock starts ticking. Clinics are not always close to where women live – particularly in rural areas, and journeys can be long or subject to unexpected delays, particularly if they are reliant on public transport. The result of this is that women can and do begin to miscarry as they travel home – a process that involves painful cramping and heavy bleeding.

The current procedure is also preventing women from accessing lawful care. A paper published in the journal Contraception in September 2017 found that in a four month period alone, over 500 British women sought abortion pills from just one online provider, Women on Web. Women found it difficult to attend multiple appointments when they lived some distance from the clinic or had limited transport, were victims of domestic violence or coercive behaviour and could not risk their privacy being compromised, or due to work and childcare commitments. Failure to allow home use has put obstacles in the way of women's access to lawful care, and women risk prison if they take pills bought online.

Women's experiences

Three women relate their recent experiences of being forced to miscarry as they travelled home:

"I had to go straight from work to the clinic to take the second medicine and then had to get home on the bus whilst in the worst pain I have been through. ***The cramps are horrendous and sitting on a bus for an hour whilst you can feel yourself bleeding and not knowing whether you were actually going to pass it before you even got home was a horrific experience****."*

"I travelled an hour and half to get to my chosen clinic and I was panicking a lot on the way home as ***cramping started about half an hour into the journey and I didn't know how much blood to expect.*** *I was so nervous."*

"I had such bad cramps ***I had to book a hotel on the way home and deal with it there****,* ***on the bathroom floor****. It was the most traumatic experience of my life to date. No women should have to do that, alone and in pain."*

Improving provision

What is home use?

The proposed solution to these issues is simple, safe, and is already in place in countries around the world, including Scotland. That solution is home use of misoprostol.

Home use means that women would attend a clinic for consultation and to take the first part of the EMA – mifepristone – and take the second pill – misoprostol – home with her to administer in the next 72 hours.

Political delivery

The Secretary of State for Health and Social Care already has the power, under the Abortion Act 1967, to allow the home use of misoprostol. This power was confirmed in a 2011 legal challenge that bpas brought against the Department of Health to allow home use – though the Secretary of State has thus far chosen not to exercise it.

Because of the Department of Health and Social Care's refusal to look at how the care of women undergoing early medical abortion might be improved, bpas remains in the peculiar position where, if a woman comes to the clinic having had an early miscarriage, she can leave with misoprostol tablets in her shoulder bag; if she has come for an abortion, she has to return on another occasion to insert the tablets into her own vagina.

Scotland

Both Scotland and Wales have the power for their own Secretaries of State to make decisions about the home use of misoprostol. There have been calls by politicians in both England and Wales to approve home use in recent years.

In October 2017, the Scottish Government announced that they would be allowing women in Scotland to take home misoprostol as part of their termination. Women must meet a certain number of clinical requirements with regards to their health and home circumstances (e.g. there must be another adult at home with them during the passing of the pregnancy). Women are not required to take the pills at home and can opt either for Early Medical Discharge (taking the pills then leaving) or to remain in hospital to pass the pregnancy. Early figures suggest that almost all eligible women are opting to take the pills home and miscarry there.

Safety

Home use of misoprostol is standard practice in most countries where early medical abortion is available, and it is recommended by the World Health Organisation as a “safe option for women”. Indeed women who are experiencing a missed miscarriage in the UK are given misoprostol to take at home so they can be in the comfort and privacy of their own home when the pregnancy passes. This is practice at BPAS and in many NHS settings, e.g. St Guy’s and St Thomas’, and Royal Berkshire. So the decision not to allow home use of misoprostol once a woman has met the legal criteria of the 1967 Act is not a safety one.

In 2007, the House of Commons Science and Technology Select Committee (STC) published a thorough and wide-ranging report on scientific developments relating to the 1967 Abortion Act. The Committee noted:

'We were impressed by the evidence that there are no particular safety concerns about early medical abortions on three grounds. First, the studies that have assessed the safety of medical abortions have been conducted so as to compare the relative safety of procedures with letting a pregnancy continue to term. The fact that medical abortions also cause unpleasant symptoms is not a reason for restricting the administration of misoprostol to a clinic; especially when the majority of women choose to go home after taking misoprostol, presumably because they want to be as comfortable as possible when these symptoms manifest. Second, the reported mortalities associated with medical abortions are “rarer than anaphylaxis after being given a shot of penicillin”. Thirdly, women already take misoprostol at home to complete natural miscarriages with no apparent safety concerns.'

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