Written evidence submitted in a personal capacity by Mr Kevin Duffy to the Criminal Justice Bill Committee.

Executive Summary

- Self-management of a medical abortion at 12-weeks or greater gestational age is considered unsafe, and thus not to be recommended, by the World Health Organisation, the Royal College of Obstetricians and Gynaecologists, and the abortion drug manufacturers. The WHO notes there is only available evidence for safe self-management of medical abortion by women for pregnancy durations up to 10 weeks (70 days).
- Given the increased risk of abortion failure, the increased risk of uterine rupture, and the risk of a live-birth, it is understandable why both the WHO and the RCOG do not recommend self-managed abortion at 12-weeks or more. These are the very cases that would be enabled by the proposed amendments, NC1 and NC2.
- The Committee should reject both amendments NC1 and NC2. Removing women from the current abortion law will lead to many more women choosing to self-manage their abortions in an unsafe manner. This increase in the number of unsafe abortions will cause more trauma to women than may have been caused by past prosecutions. Changing investigation, prosecution, and sentencing guidelines is a much safer approach to improving care for these vulnerable women.

Introduction

1. I am writing this in response to the proposed amendments to the Criminal Justice Bill NC1 and NC2 submitted by MPs Dame Diana Johnson and Stella Creasy, respectively. Whilst different in the approaches taken, both seek to ensure that no woman would be liable for prosecution as a result of seeking to end her own pregnancy at any gestation.

2. Telemedicine abortion with pills-by-post is legally available up to 9-weeks-6-days gestational age (GA). Abortion in an approved healthcare facility is available up to 23-weeks-6-days GA. It is most likely that any such prosecutions would arise in cases in which a woman self-manages her medical abortion after 10-weeks GA or, more worryingly, after 24-weeks GA. It is most likely that the woman would obtain the abortion pills from an NHS provider using the telemedicine service by simply lying about the gestational age of her pregnancy, as happened in the Carla Foster case.[1]

3. In its 2022 updated guidance, the World Health Organisation (WHO) considers a self-managed medical abortion at 12-weeks or greater GA to be unsafe.[2] In its recently published position statement, the Royal College of Obstetricians and Gynaecologists says that it endorses the WHO's Abortion care guidelines on self-managed abortion.[3]

4. The current law protects women from unsafe abortion and the threat of prosecution may be the reason why so few cases have arisen. Removing women from the criminal law related to abortion will result in many more women choosing to obtain the abortion pills from an NHS provider and self-administering these at a gestational age of 10-weeks or

greater, in a manner considered unsafe by the WHO, the RCOG, and the abortion drug manufacturers. This might lead to unnecessary harm and trauma for these vulnerable women.

WHO Abortion care guideline, 2022

5. In 2022, the World Health Organisation updated its abortion care guideline to include Recommendation 28 stating that it is safe for women to self-manage their medical abortion when their pregnancy is less than 12-weeks gestational age. The WHO notes however that there is only available evidence for safe self-management of medical abortion by women for pregnancy durations up to 10 weeks (70 days).

6. In the same guideline, Recommendation 30 states that medical abortion at 12-weeks or greater should only be managed by medical practitioners (doctors). It includes a weaker suggestion that nursing staff and lower cadres could be involved but "only in contexts where established and easy access to appropriate surgical backup and proper infrastructure is available to address incomplete abortion or other complications." Self-management by women at 12-weeks or more is not included in either the recommendation or suggestion.

7. Recommendation 29 suggests for medical abortion at or greater than 12-weeks, a misoprostol dose of 400 µg, which is half the dose it suggests for medical abortion at less than 12-weeks, and one-third of the dose typically included in the pills-by-post packages. Noting that whilst uterine rupture is rare, the guideline includes a warning that providers need to use clinical judgement and caution when treating women who have previously given birth by caesarean section and to further reduce the dose of misoprostol for induced abortion beyond 24-weeks GA, due to the greater sensitivity of the uterus to misoprostol as gestation increases.

8. Recommendation 30, when addressing the 'Where' states: "Medical abortion for pregnancies at gestational ages ≥12 weeks has been practised and researched as a facility based procedure during which women should remain under observation until the process is complete."

9. The World Health Organisation defines a 'safe' abortion as: "meaning that they are carried out using a method recommended by WHO, appropriate to the gestational age, and by someone with the necessary skills." This 2022 guideline does not consider the woman herself to be someone with the necessary skills to perform or participate in the provision of a medical abortion at or after 12-weeks gestation, and so a self-managed abortion at or after 12-weeks would be deemed 'unsafe' by the WHO.

10. In summary, the World Health Organisation best-practice guideline for safe medical abortion is that it should only be self-managed by the woman herself when gestational age is less than 12-weeks. A medical abortion at 12-weeks or greater must be managed by a medical practitioner in a healthcare facility with easy access to the surgical backup necessary to treat any complications that might arise.

Royal College of Obstetricians and Gynaecologists guidelines

11. The Royal College of Obstetricians and Gynaecologists notes in its position statement on self-managed abortion that it "endorses the WHO's recommendation that self-managed medical abortion up to 12 weeks of pregnancy is a safe and effective abortion method…" This position statement makes no mention of self-management at greater than 12-weeks, and so one can presume that the RCOG also endorses the WHO recommendation against such unsafe practice.

12. In its 'Best practice in abortion care', updated in 2022, the RCOG echoes the WHO cautionary warning that "The uterus is more sensitive to misoprostol as pregnancy advances, and therefore, in pregnancies over 24 weeks, lower doses of misoprostol should be used and increased intervals between misoprostol doses may be considered, especially for people with uterine scars." [4]

13. In Table 2 of the above publication, RCOG notes that for medical abortions when GA is 14-weeks or more, there is a 13% risk that the abortion will be incomplete and that a further medical intervention will be required to complete the procedure, to avoid prolonged bleeding or infection. This risk is twice the stated 7% for abortions at lower GA.

14. In a related 'Making Abortion Safe' summary sheet, RCOG states that providers should consider feticide before a medical abortion for gestational ages from 22-weeks. It says this is to "avoid [the] fetus being born with signs of life, which can cause distress for patients and care providers." [5]

15. In summary, RCOG endorses the WHO recommendations that it is best practice for self-managed abortion to be limited to less than 12-weeks gestational age. Women who are self-managing their abortion will be unable to follow the RCOG best-practice of feticide when the GA is 22-weeks or more and might cause themselves unnecessary harm if using the full 1,200 µg dose of misoprostol included in the NHS pills-by-post package. The increased risk of an incomplete abortion means that at least 1-in-7 women self-managing their abortion after 14-weeks will require hospital treatment to safely complete the abortion.

Summary of Product Characteristics – SmPC

16. The Summary of Product Characteristics (SmPC) for the abortion pills manufactured by Ranbaxy and Linepharma, as used by BPAS and MSI Reproductive Choices respectively, state that the drugs (mifepristone and misoprostol) "SHOULD NEVER [their emphasis] be prescribed in the following situations: pregnancy not confirmed by gynaecological examination, ultrasound scan or biological tests, or pregnancy beyond 63 days of amenorrhoea [9-weeks GA]…" [6] [7]

17. Both manufactures state that because of a non-negligible risk of failure, of up to 7.8% for GA less than 9-weeks, there must be a follow-up clinical visit to check that the abortion is complete.

18. Latest official data for abortion statistics in England and Wales show that 52% of all abortions in the first half of 2022 were performed solely by telemedicine; these 66,310 procedures were provided by the NHS using the abortion pills off-label, not following the SmPC guidance that gestational age must be confirmed clinically, rather than by the woman herself and without the recommended follow-up clinical visit.

Recommendations

19. I agree with those tabling these amendments that the police investigations and legal prosecutions can cause undue emotional trauma and harm for these vulnerable women. They cite six cases in the last year, which I consider to be a strong indication that the current law is working. Six cases from at least 120,000 telemedicine abortions in a year, is a small proportion that, no doubt, would have been much higher had there not been the threat of prosecution.

20. Instead of changing the law the Committee might want to consider new guidelines for police investigation and subsequent legal prosecutions. New guidelines could recommend non-custodial sentences and provision of emotional support and any necessary care to help women deal better with these challenging situations.

21. The Committee should reject both amendments NC1 and NC2. Removing women from the current abortion law will lead to many more women choosing to self-manage their abortions in an unsafe manner that is not supported or recommended by either the World Health Organisation or the Royal College of Obstetricians and Gynaecologists. This increase in the number of unsafe abortions will cause more trauma to women than may have been caused in past prosecutions. Changing investigation, prosecution, and sentencing guidelines is a much safer approach to improving care for these vulnerable women.

About the author

22. I worked for four years (2013-16) as a director at Marie Stopes International (now MSI Reproductive Choices) with responsibility for its overseas abortion clinics, more than 500 clinics in 30 countries; I was engaged by MSI for a further 2 years (2017-18) as an independent consultant providing continued support to its international clinics management teams.

References

[1] Carla Foster, Sentencing Remarks 12 June 2023 – CrimeLine - https://crimeline.co.uk/carla-foster-sentencing-remarks-12-june-2023/ accessed 15 January 2024

[2] Abortion care guideline. Geneva: World Health Organization; 2022. https://www.who.int/publications/i/item/9789240039483 accessed 15 January 2024

[3] RCOG – Position statement: Self-managed abortion - https://www.rcog.org.uk/about-us/campaigning-and-opinions/position-statements/position-statement-self-managed-abortion/ accessed 15 January 2024

[4] Royal College of Obstetricians and Gynaecologists, Best practice in abortion care - https://www.rcog.org.uk/guidance/browse-all-guidance/best-practice-papers/ accessed 15 January 2024

[5] Royal College of Obstetricians and Gynaecologists, Making abortion safe – summary papers, Medical abortion from 12 weeks of pregnancy: Summary sheet 1. https://www.rcog.org.uk/about-us/global-network/centre-for-womens-global-health/our-approach/our-resources/making-abortion-safe/ accessed 15 January 2024

[6] Ranbaxy Medabon (mifepristone and misoprostol) SmPC - https://www.medicines.org.uk/emc/product/3380 accessed 15 January 2024

[7] Linepharma Mifepristone SmPC - https://www.medicines.org.uk/emc/product/14350 accessed 15 January 2024