Chief Medical Officer for Scotland

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Dear Colleague

Abortion – Updated approval on taking abortion medications outwith the hospital or clinic

Purpose

1. This letter is to notify you that Scottish Ministers have granted a new approval relating to Early Medical Abortion at Home (EMAH) and other abortion provision outside a hospital or clinic. The new approval combines the previous EMAH approval of May 2022[1] and also the approval of August 2023[2]. The new approval continues to allow both stages of early medical abortion treatment to be undertaken in a patient's home in certain circumstances (as with the May 2022 approval) as well as mifepristone to be taken in a patient's home as the first stage of a medical abortion at all gestations up to the legal limit, when a medical practitioner or nurse decides that it is clinically appropriate (as with the August 2023 approval). **This new approval came into force on 4 December 2024.**

2. In addition, the new approval will allow midwives to carry out telemedicine and in-person consultations for abortion patients and will allow patients to take mifepristone and/or misoprostol in temporary or residential accommodation in certain circumstances.

Updated Approval

3. The updated approval at **Annex A** replaces both of the approvals (2022 and 2023) referenced above. The provisions of both previous approvals have been combined into the new approval and will therefore continue to apply alongside the further changes.

4. The new approval applies for EMAH cases where the patient has had a consultation with either a doctor, nurse or midwife in-person or remotely via telephone or video call (i.e. telemedicine) and a doctor has prescribed mifepristone and misoprostol for the purposes of termination of their pregnancy.

From the Chief Medical Officer for Scotland

Professor Sir Gregor Smith

17 December 2024

SGHD/CMO(2024) 21

Addresses

For action
Territorial NHS Board Chief Executives
Territorial NHS Board Medical Directors

For information
Directors of Public Health
Women's Health Leads
NHS Abortion Leads
Sexual Health and BBV Strategic Leads
Fetal Medicine Leads
Private Hospital Abortion Service Managers

Further Enquiries

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[1] See https://www.publications.scot.nhs.uk/files/cmo-2022-23.pdf
[2] See https://www.publications.scot.nhs.uk/files/cmo-2023-16.pdf

5. In addition, the patient needs to have either attended a hospital or approved abortion clinic and taken mifepristone and wants to take misoprostol in residential or temporary accommodation, or the patient wants to take both mifepristone and misoprostol in residential or temporary accommodation.

6. The accompanying guidance produced by the Scottish Abortion Care Providers (SACP), attached alongside this letter (**Annex B**), indicates that these EMAH options should be offered to patients up to 12 weeks gestation. This guidance should continue to be followed for the provision of EMAH, although it will be updated shortly to refer to the additional flexibilities provided by this new approval.

7. The new approval also applies (similarly to the August 2023 approval) in the circumstances where the patient has attended a hospital or approved abortion clinic for an appointment, where she will be expected to have had an ultrasound scan or other tests or procedures required prior to taking mifepristone. Patients need to have had a consultation with either a doctor, nurse, or midwife as well, although this consultation can either take place as an in-person appointment or a telemedical appointment. A doctor must prescribe the patient mifepristone to be taken for the purposes of termination of her pregnancy and the patient must want to take the mifepristone in residential or temporary accommodation. The approval will permit mifepristone to be taken as the first stage of a medical abortion at all gestations up to the legal limit, when a medical practitioner, nurse or midwife decides that it is clinically appropriate, and these circumstances apply.

8. The new approval allows for three additional changes:

    (i) For midwives to carry out pre-abortion consultations with patients over the phone, via video-link or in-person before one or both medications are taken at home or another location outwith a hospital/clinic.
    (ii) For doctors to be permitted to prescribe abortion medication from home to be used for treatment in any type of medical abortion that takes place in part or fully outwith the clinical setting.
    (iii) For patients to be able to take one or both parts of their abortion medication in temporary or residential accommodation in certain circumstances (rather than being limited only to the patient's home).

9. Under the new approval, registered midwives can now carry out telemedicine or in-person consultations in advance of a medical abortion at home - under the previous approval only a doctor or a nurse were able to carry out these consultations. Two doctors will still be required to sign Certificate A, and midwives carrying out consultations should follow the existing, attached, SACP guidance.

10. The new approval will also permit doctors to prescribe abortion medication from home to be used for treatment in any type of medical abortion that takes place in part or fully outwith the clinical setting. Previously, this was only permitted under the 2022 approval. The effect of the new approval is that doctors may prescribe from home either:

    (i) mifepristone and misoprostol where the pregnant woman has attended a clinic or hospital and taken mifepristone and wants to take misoprostol in residential or temporary accommodation, or where the pregnant woman wants to take mifepristone and misoprostol in residential or temporary accommodation; and
    (ii) mifepristone to be taken at residential or temporary accommodation where the woman will attend a hospital or clinic to take misoprostol.

This change has been made to provide flexibility for NHS Boards where doctors are working remotely.

Temporary and Residential Accommodation

11. Ministers recognise that there are certain circumstances where a patient's 'home' (in other words where they are 'ordinarily resident') is not the most appropriate place for them to take their abortion medication. The new approval therefore approves residential accommodation and temporary accommodation as classes of places where abortion medication can be taken. This will allow a patient to take one or both of the medications mifepristone and misoprostol in either residential accommodation or temporary accommodation where it is clinically appropriate.

12. The Scottish Government understands from abortion services that some patients would feel more comfortable or more able to access emotional support by staying at someone else's home. By broadening the places approved to all residential accommodation, this will enable patients to take their medication at, for example, a friend, family member or partner's home, as well as continuing to permit the patient to take it in their own home. The residential accommodation where the medication is taken must be in Scotland.

13. Similarly, the approval also now provides extra flexibility for patients to take their medication in temporary accommodation. Temporary accommodation means any place providing lodgings and it must be in Scotland. The Scottish Government is aware that some Health Boards would prefer to arrange short-term let accommodation for patients who live a significant distance from an emergency department to allow them to be near a hospital after taking misoprostol in case of any complications.

14. As part of the pre-abortion consultation, the health worker should determine whether it would be more appropriate for a patient to take one or both parts of their abortion medication in temporary accommodation, or in residential accommodation other than the patient's home. Health workers should continue to follow the standard safeguarding procedures and relevant guidance when discussing treatment pathways with individual patients. Services should continue to ensure, as for all EMAH and other medical abortion patients, that patients have clear guidance on how and when to take the medication, information about potential side effects and risks, and phone numbers for them to call if they have any concerns.

Action

15. Chief Executives of NHS Boards should ensure that these changes are brought to the attention of all relevant staff, including abortion service, Fetal Medicine staff and pharmacy staff.

Yours sincerely

Gregor Smith

Professor Sir Gregor Smith
Chief Medical Officer for Scotland

The Abortion Act 1967 (Place for Treatment for the Termination of Pregnancy) (Approval) (Scotland) 2024

The Scottish Ministers make the following approval in exercise of the powers conferred by section 1(3) and (3A) of the Abortion Act 1967[1], and all other powers enabling them to do so.

Commencement

1. This approval comes into force on the day after the day on which it is made.

Interpretation

2. In this approval—

"approved place" means a hospital in Scotland, as authorised under section 1(3) of the Abortion Act 1967, or a place in Scotland approved under that section but does not include a place forming part of a class of place that is so approved (see section 1(3A)(a) of that Act),

"home of a registered medical practitioner" means the place in Scotland where the registered medical practitioner is ordinarily resident,

"pregnancy" and "pregnant woman" are to be construed by reference to the Abortion Act 1967,

"temporary accommodation" means any place providing lodgings.

Approval of class of place

3. For the purposes of section 1(3) of the Abortion Act 1967, the following are approved as classes of places for treatment for the termination of pregnancy where the treatment is carried out in the manner specified in paragraph 5 or 6:

(a) residential accommodation in Scotland; and

(b) temporary accommodation in Scotland.

4. The home of a registered medical practitioner is approved as a class of place for treatment for the termination of pregnancy for the purposes only of prescribing the medicines known as mifepristone and misoprostol to be used in treatment carried out in the manner specified in paragraph 5 or 6.

5. The treatment must be carried out in the following manner—

(a) the pregnant woman has had a consultation with a registered medical practitioner, or with a registered nurse or registered midwife acting under the direction of a registered medical practitioner, at an approved place or by means of video link or telephone;

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[1] 1967 c. 87. The functions of the Secretary of State were transferred, so far as exercisable in or as regards Scotland, to the Scottish Ministers by virtue of the Scotland Act 1998 (Transfer of Functions to the Scottish Ministers etc.) Order 1999. Section 1(3A) was inserted by section 37(3) of the Human Fertilisation and Embryology Act 1990 (c. 37).

(b) a registered medical practitioner has prescribed the pregnant woman mifepristone and misoprostol for the purposes of termination of her pregnancy; and

(c) the pregnant woman—

(i) has attended an approved place where she has taken mifepristone and wants to take the misoprostol at residential accommodation or temporary accommodation; or

(ii) wants to take the mifepristone and misoprostol at residential accommodation or temporary accommodation.

6. The treatment must be carried out in the following manner—

(a) the pregnant woman has had a consultation with a registered medical practitioner, or with a registered nurse or registered midwife acting under the direction of a registered medical practitioner, at an approved place or by means of video link or telephone;

(b) the pregnant woman has attended an approved place prior to, as part of, or following the consultation described in sub-paragraph (a), for an ultrasound scan or other tests or procedures required in advance of taking mifepristone;

(c) a registered medical practitioner has prescribed the pregnant woman mifepristone to be taken for the purposes of termination of her pregnancy; and

(d) the pregnant woman wants to take the mifepristone at residential accommodation or temporary accommodation.

Revocation

7. The Abortion Act 1967 (Place for Treatment for the Termination of Pregnancy) (Approval) (Scotland) 2022[2] and the Abortion Act 1967 (Place for Treatment for the Termination of Pregnancy) (Approval) (Scotland) 2023[3] are revoked.

Jenni Minto .

Authorised to sign by the Scottish Ministers

[Date] 3rd Dec 2024 .

[2] Made on 12 May 2022.
[3] Made on 21 August 2023.

Scottish Abortion Care Providers network

Guidelines for early medical abortion service provision up to 11+6 weeks

Contents

Purpose 2
Overview 2
Background 2
Pre-abortion Consultation Process 3
1. Initial triage and patient information 3
2. Pre-abortion Consultation 3
3. Abortion Procedure 7
4. Completing paperwork and providing medications 9
Criteria for Ultrasound Scanning and taking medications at home 9

Guidance last updated November 2023

Purpose

Surgical, medical in hospital and medical at home abortions should be available when clinically and socially appropriate for pregnancies under 12 weeks. This document sets out the current pathways for abortion under 12 weeks. In relation to early medical abortion at home, it builds on the existing RCOG guidance on 'Best practice in telemedicine for abortion care'[1].

Patients **up to 11 weeks + 6 days gestation** should be able to choose to self-administer mifepristone and/or misoprostol at home, rather than at a healthcare facility where they meet the inclusion criteria. The below guidance recommends the circumstances in which these options are appropriate.

Overview

There are a range of scenarios available for early abortion care. The most appropriate pathway for patients will be made after individual discussion of clinical and social factors. Informed choice is central to abortion care, and patients should be provided with the information required to make an informed choice. In some cases, safety concerns may mean that not all options are offered to every patient.

Decisions will need to be made around:

- Whether the consultation will be by video-call, phone or in person
- If the patient requires, or chooses, an ultrasound scan
- If further testing is required, including blood tests, STI testing, antibiotics and VTE prophylaxis
- Whether the patient wishes to proceed with a surgical, medical in hospital or medical at home procedure
- Whether medication is administered in clinic/hospital, supplied in clinic or by courier/post or at another location, such as a pharmacy.

More details on each of these aspects of treatment are provided in these guidelines.

Background

Evidence has demonstrated that early medical abortion at home with self-administration of mifepristone and misoprostol is a safe method of abortion for the vast majority of patients. It can reduce delays and allow patients to complete treatment in their home surroundings if they wish. An expert evaluation of early medical abortion at home (EMAH) in Scotland considered in detail the risks and benefits of the approaches used by Scottish Health Boards[2]. It concluded the benefits for the great majority of patients and staff outweighed the risks. This is consistent with the recommendations from the World Health Organisation and the Royal College of Obstetricians and Gynaecologists.

Women meeting the inclusion criteria should not be required to attend the clinic for the administration of mifepristone or misoprostol. They can self-administer both

[1] See https://www.rcog.org.uk/media/f32nniuk/abortion-care-telemedicine-best-practice-paper-2022.pdf

[2] See Telemedicine early medical abortion at home: evaluation - gov.scot (www.gov.scot)

mifepristone and misoprostol at an agreed time interval between the two medications, thus completing treatment without the need for an in-person visit.

However, some patients will be advised, or may choose to, have their medical abortion in hospital for clinical or social reasons and some patients will choose to have a surgical abortion.

Pre-abortion Consultation Process

1. Initial triage and patient information

Health Boards should offer all patients seeking an abortion a consultation and treatment in line with the criteria set out in Standard 10: Abortion Care of the Healthcare Improvement Scotland sexual health standards of 2022[3].

Patients should be able to contact the abortion service directly rather than needing a clinician referral.

Services should offer information about the abortion process to patients in advance of their consultation. Services can either direct patients to their website/the NHS Inform website or send links directly to patients by text message or email (where appropriate data security arrangements are in place).

Patients should be offered a choice between having their initial clinician consultation either **via video call, via telephone or in person in a clinic**, although video call should be encouraged over telephone consultations where possible for those patients who have the technology (smart phone or tablet/computer) to access this. For appointments via video call, 'Near Me' is recommended, although other secure video call technology can be used where this is approved by the Health Board (see RCOG guidance on 'Best practice in telemedicine for abortion care'[4]).

2. Pre-abortion Consultation

The consultation should largely cover the same information whether the patient has their consultation via telephone, via video call or in person. If an interpreter is required, language line should be used.

At the start of a telemedicine consultation, the health worker should check the patient's identity, that they are somewhere they can talk privately and are comfortable they can speak freely.

All consultations should involve seeking the following information from patients about their pregnancy and medical history:

- Estimated gestation based on factors including their last period, contraceptive use, pregnancy test, date of sexual activity.
- Experience of any symptoms such as pain, bleeding or hyperemesis.

[3] See in particular pages 39-41 at Sexual health standards (healthcareimprovementscotland.org)

[4] See abortion-care-telemedicine-best-practice-paper-2022.pdf (rcog.org.uk)

- Relevant medical conditions – including risks for haemorrhage or thrombosis.
- Relevant surgery – e.g. gastric bypass/sterilisation.
- Drug and allergy history, including recreational drugs.
- Past pregnancies and outcomes.
- Reasons for considering abortion and indications of any coercion.
- Social challenges and support – including for a home medical abortion.

The health worker should use the information gathered to determine which abortion options are suitable and whether an ultrasound scan or other tests are required. The health worker may need to liaise with other colleagues or other specialities before making this decision.

The health worker and patient should then discuss as appropriate:

- Their options for treatment (or continuing their pregnancy if they are not fully certain about whether to have an abortion), including discussion of inpatient medical or surgical abortion even if eligible for home abortion.
- The procedure, risks and recovery for each option, including likely pain and bleeding.
- Their need or wish for ultrasound to confirm gestation, site and viability.
- Their need or wish for an in person appointment for further consultation or medicine supply/administration.
- Their need or wish for STI tests, blood tests for Rh status, FBC, etc.
- When and how to get advice before, during or after the abortion.
- How to access further counselling before and after abortion.
- Their contraceptive options and supply.
- Their need for antibiotic prophylaxis.
- Their VTE risk and need for prophylactic LMWH.

Further guidance on a number of these points is provided below.

Where patients are being offered a choice on any of the above, they should be provided with all the information on any relevant risks so an informed choice can be made. In particular, they should be made aware that a scan will accurately date their pregnancy and may confirm that a pregnancy is in the uterus. They should be told that if they proceed without a scan there may be a risk that, if their gestation is wrong, they may pass a later than expected gestation pregnancy which could put them at some greater risk of complications if passing their pregnancy at home. They should also be told that an ultrasound scan could help detect if they have an ectopic pregnancy.

Health Boards may develop local pro-formas, guidance and patient information. Written information should be provided for each patient to support the consultation; this may be a leaflet or text or email. All patients should be given telephone numbers for advice at any time; day or night, as well as advice on when to seek emergency help via 999 or go direct to hospital.

Whilst both mifepristone and misoprostol should be available for administration in the home setting up to 11+6 weeks gestation where this is appropriate for them, services may wish to consider encouraging women who live a significant distance from a

hospital and are over 9+6 weeks gestation to take misoprostol in the hospital clinic setting.

The health worker should ensure patients have sufficient opportunities to ask questions and ensure that the patient is making their own decision about whether to end the pregnancy.

If the patient has not decided whether to proceed with an abortion or which method to choose, the health worker should explain time limits for each abortion option and agree on how to make further contact with the service. If they are unsure, the health worker should offer pre-abortion counselling if appropriate.

STI testing and prophylaxis treatment

STI testing for chlamydia, GC +/- TV can be offered to all patients seeking abortion or to those at higher risk (e.g. under 25 years old, any age where they have had a new partner in the last year, more than 1 partner in the last year or their partner has other partners).

The STI swab can be done in clinic or a home testing kit provided.

Prophylactic antibiotics may be prescribed for all or selected patients. Each Health Board needs a pathway for risk assessment and antibiotic supply consistent with RCOG guidance.

BBV testing can either be offered to all patients or only those with risk factors for infection. This may be within the abortion service or local SRH service or primary care, depending on local arrangements.

There must be a robust pathway for communicating results and arranging treatment and partner notification.

Rhesus Status

Current NICE guidance recommends Anti-D prophylaxis for patients having medical abortion from 10+0 weeks gestation. It advises considering Anti D prophylaxis for Rhesus negative patients having surgical abortion at any gestation.

There is limited evidence about the risks of isoimmunisation after medical abortion between 10 and 11+6 weeks and the guidance is under review by the British Haematology Society.

In the meantime services should discuss the potential benefits of Anti-D after medical abortion between 10 and 11+6 weeks for Rhesus negative patients who may have a future pregnancy. The patient can decide whether to have Rhesus testing/ Anti-D administration.

Other blood tests

The clinical history may suggest that other blood tests are needed before deciding whether home abortion is suitable and for optimising inpatient care, for example a history or symptoms of anaemia or ITP.

These tests should be arranged at the most appropriate clinical location.

Patients of relevant ethnic origin may benefit from knowing if they carry a haemoglobinopathy. This may affect decisions about the current pregnancy or future pregnancy. Testing can be discussed and may be offered in the service or the patient advised to seek testing in primary care.

Thrombosis prophylaxis

All patients should have a VTE risk assessment at the initial consultation and be offered prophylactic LMWH if they are at higher risk. Prophylaxis should start as soon as possible.

Guidance is available from RCOG and British Haematology Consensus Group. Local discussion between the abortion service and local haematology departments is likely to be needed to clarify details.

Each Board should have a policy for assessing risk and for supplying LMWH when needed.

Contraception

The health worker should offer the chance to discuss contraceptive options. This should be done sensitively as some patients will not want to talk about future contraception during the abortion consultation.

Patients who wish to discuss contraception should be asked about their preferences and advised if any methods are not suitable for medical reasons.

Patients who do not want to discuss contraception should be informed about the timing of the resumption of fertility after an abortion. They should also be advised where they can access contraceptive advice and services if needed in the future.

Any patient can be offered further information by text or email or links to local or national websites.

Contraception can be supplied/administered at the abortion clinic or by post/courier or at another location e.g. pharmacy or during hospital admission. When possible and appropriate give a six month supply of combined hormonal contraception/ SayanaPress/POP. A longer supply may be appropriate in some cases.

Each Board should have a robust system for prompt LARC administration after abortion. The abortion service should provide bridging contraception if a LARC is not fitted immediately. This may be a 3 to 6 month supply of combined hormonal contraception or POP depending on medical eligibility and preference.

3. Abortion Procedure

Inpatient medical or surgical abortion

The abortion service can administer or supply mifepristone for home administration before hospital medical abortion.

The health worker should provide the patient with verbal and written information about the procedure including:

- When to take home medication before admission if needed
- When and where to attend for procedure
- Fasting advice when relevant
- When to seek medical advice before or after the procedure
- 24/7 Contact details for advice if any queries or if they vomit mifepristone within 2 hours.

The abortion service should arrange for the patient to complete consent forms for the abortion procedure and disposal of pregnancy tissue according to local practice.

The abortion service should provide clinical information to the hospital team and GP according to local practice.

The abortion service should prescribe inpatient abortion medication, analgesia, contraception and antibiotics according to local practice.

Home medical abortion

The health worker should ensure that the patient understands how and when to administer the abortion medication. More than one contact may be needed.

The health worker should provide the patient with personalised verbal and written information. This may be a leaflet or by text or email.

This should include:

- when to seek medical advice before or after the procedure.
- 24/7 contact numbers for any queries or if vomits mifepristone within 2 hours.
- disposal of pregnancy tissue

The early medical abortion at home pack may be collected from clinic or sent by Royal Mail special or recorded delivery or courier or to another location e.g. a pharmacy according to local policy. If a courier/post is used confirm address details and delivery time and date and action to take if the pack does not arrive.

The medication pack should include:

1. Mifepristone 200mg oral tablet: advise the patient to contact the service if they vomit within 2 hours of swallowing. Consider providing antiemetic prior to mifepristone if nauseous.

2. Misoprostol:

- 200mcg tablets x 6 as standard.
- 800mcg (4 tabs) PV or SL or buccal. If SL buccal advise patient to keep the tablets in mouth and do not drink/eat for 30 minutes. Vomiting is more likely with SL/buccal route and the tablets may cause dryness/tingling in mouth and throat.
- 400mcg (2 tabs) to take 4 hrs later PV or SL/buccal if bleeding (not needed IF the patient is certain that the fetus and placenta have been passed).

The dose does not need to be repeated if vomiting or vaginal tablets expelled after 30 minutes.

A further 400mcg dose should be supplied at 10-11+6 weeks gestation as per local policy.

3. Analgesia- as per local policy. Patients may purchase NSAID and paracetamol. Dihydrocodeine 30mg tabs can be supplied.

4. Antiemetic – as per local policy

5. Low sensitivity pregnancy test threshold 1000 iu/l to do after 14 days to exclude ongoing pregnancy. Provide patient with an Information leaflet with details of action if test is positive.

6. Contraceptive supply – bridging/long-term as appropriate

7. Prophylactic antibiotic supply as appropriate

8. STI testing kit as appropriate

Further Guidance for patients taking their medications at home

1. Advise that the patient should have an adult at home with them for support on the day that they self-administer misoprostol. They should not be responsible for childcare on that day.

2. Advise that the misoprostol is most effective when taken 24-48 hours after the mifepristone. A gap less than 24 and more than 72 hrs has a higher incomplete/ failed abortion rate. Unscheduled bleeding is more likely if the misoprostol is delayed more than 48 hours.

3. Advise the patient to seek advice if they experience very heavy bleeding (for example around 2 pads an hour for 2 hours) or are worried about the amount they are bleeding.

- Advise the patient to seek advice from abortion service if there has not been heavy bleeding and cramps on the day of misoprostol with bleeding continuing for at least 4 days total.

- Provide specific advice for patients between 10 and 11+6 weeks who have not passed the pregnancy after 3 doses misoprostol as per local policy.

4. Completing paperwork and providing medications

After the consultation process, including any in-person appointments, and when verbal consent is provided to proceed with self-administration of medications in the home setting, services should complete EMAH paperwork, detailing patient understanding of treatment, the information that has been provided on what to expect at home (including information leaflet) and the 24 hour contact information for advice/concerns or emergency contact. Services should also document when the patient will conduct the pregnancy test to confirm success of procedure. The abortion service will complete legal documentation for the abortion procedure.

Criteria for Ultrasound Scanning and taking medications at home

Where any of the following apply, the patient is to be asked to attend the hospital or clinic for an ultrasound scan before proceeding with early medical abortion. Where a patient is not required to attend a hospital or clinic setting for an ultrasound scan or other appropriate tests for any of the reasons set listed in the below criteria, they should still be offered an appointment for an ultrasound scan if that is their preference.

Ultrasound is usually required if any of the following risks are identified:

1. Uncertainty about gestation:
    - Unsure of LMP, abnormal LMP, no regular cycle, using hormonal contraception
    - No normal period since they discontinued hormonal contraception
    - No normal period since emergency contraception

2. Increased risk ectopic:
    - Previous ectopic
    - Previous tubal surgery or sterilisation
    - Intrauterine contraceptive in situ

3. Possible failing/ectopic pregnancy:
    - Clinically relevant pain or bleeding as assessed by the health worker

4. Potential safeguarding issues:
    - Under 18
    - No registered GP
    - Vulnerable
    - Communication difficulty
    - Any other concern re patient’s ability to estimate gestation accurately, such as a chaotic lifestyle

5. Patient wishes scan to confirm gestation and pregnancy site and to look for twin pregnancy or non-continuing pregnancy.

Inclusion Criteria for Self-Administration of Mifepristone and Misoprostol at Home

The woman/patient:

- Is certain of the decision to proceed to abortion and wishes to administer one or both of the first (mifepristone) and the second part of treatment (misoprostol) at home.
- Is ordinarily resident in Scotland and meets the criteria set out in the Ministerial approval for EMAH[5].
- Is ≤11+6 weeks gestation on the day of mifepristone administration (as calculated from the date of the last menstrual period or an ultrasound scan if applicable).
- [If applicable] Has had any recommended tests or treatments.
- Is 16 years of age or above, unless staff are satisfied that appropriate supports are in place from an adult family member(s).
- Has no significant medical conditions or contraindications to medical abortion (see below).
- Is able to understand all information given, and to follow instructions for mifepristone and misoprostol administration.
- Fully understands the need to confirm the success of the procedure in line with local protocols.

Contra-Indications / caution for mifepristone / misoprostol

Mifepristone and misoprostol should be used with caution in certain conditions. Please refer to the table below and consult RCOG guidance if needed:

Absolute contra-indications	**Caution required in the following circumstances (discuss with senior medical staff)**
Inherited porphyria	
Chronic adrenal failure	Patient on long-term corticosteroids
Known or suspected ectopic pregnancy	Asthma (avoid if severe)
	Haemorrhagic disorder or on anticoagulant therapy
Previous allergic reaction to one of drugs involved	Prosthetic heart valve or history of endocarditis
	Pre-existing heart disease
	Hepatic or renal impairment
	Severe anaemia
	Severe inflammatory bowel disease e.g. Crohn's
	IUCD in place (remove pre-procedure)

[5] See Annex A at https://www.sehd.scot.nhs.uk/cmo/CMO(2022)23.pdf