



Commentary

What if medical abortion becomes the main or only method of first-trimester abortion? A roundtable of views^{☆,☆☆}

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Received 21 March 2017; revised 10 April 2017; accepted 10 April 2017

Norway, by Kevin Sunde Oppegaard

In Norway right now, we can only speculate. Manual vacuum aspiration in Norway has been almost completely superseded by medical abortion with mifepristone+misoprostol. This has benefits for women seeking abortion, as they obtain abortion at an earlier gestational age and the waiting time has been reduced [1]. At the same time, practical skills in manual vacuum aspiration for trainees are now much more limited than they used to be; after cesarean section, the next most common gynecological procedure in Norway is abortion.

We don't know if this has consequences for women needing treatment with manual vacuum aspiration, as we don't have reliable data for complications in connection with abortion. I have personally experienced that trainees in my department are considerably less able to perform manual

vacuum aspiration, and we have quite a few complications with perforation and incomplete procedures (plural). When I started out, I spent the first 6 months doing 10–15 manual vacuum aspirations a day! Training in abortion procedures never used to be needed as part of the curriculum, as it was so common. Newly suggested national recommendations for specialist training from the Director of Health head toward even less surgical training for trainees [2].

But beyond speculation, as I've already said, the negative effects for women needing vacuum aspiration cannot be ascertained.

New Zealand, by Margaret Sparrow

Early medical abortion in New Zealand was introduced in July 1998 after abortion providers learned that the French Company Exelgyn could supply the New Zealand market with mifepristone, but only through a reputable pharmaceutical company. With none of the established firms interested, five doctors formed a not-for-profit company, Istar Limited, named after the Babylonian goddess of love, fertility and war. Registration of the new drug Mifegyne 200 mg was approved on 30 August 2001.

Initially, clinics were reluctant to use it for early terminations (up to 9 weeks' gestation) because of an ambiguity in the New Zealand law which states that all abortions must be "performed" in a licensed institution. This legal ambiguity was resolved in April 2003 when a High Court judge ruled that the two drugs (mifepristone and

[☆] Conflict of interest: Dame Margaret Sparrow was one of the five New Zealand doctors who in 1999 formed the company Istar Ltd., a not-for-profit company, specifically to import mifepristone.

^{☆☆} Permission: Article by Francisca Garcia was translated with the author's permission into English from: Aborto, ¿en la sanidad pública?, InfoLibre, 12 February 2017. http://www.infolibre.es/noticias/opinion/2017/02/12/aborto_sanidad_publica_60837_1023.html

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misoprostol) must be taken in a licensed institution, but the woman does not have to stay there between doses or until the process is complete. The legal problem may have been resolved, but the outdated laws on abortion still mean that there are barriers to providing an optimum and efficient service.

In 2015, only 10% of abortions in New Zealand were early medical abortions, indicating that, at present, there is no public demand for medical abortion. Most abortions are currently performed by suction curettage in hospital-type facilities. To change this, there may be some resistance from operating doctors skilled at surgical techniques and wishing to maintain these skills. The safety record with the present system (no deaths since reliable statistics started in 1980) is an argument used to maintain the status quo. Nor are many doctors skilled at manual vacuum aspiration.

Medical abortion will never be the only method given that there are a few contraindications, e.g., chronic adrenal failure; hypersensitivity to the medications; severe uncontrolled asthma; inherited porphyria; and severe cardiac, renal or hepatic disease. Also, there must be respect for the woman's choice. Often, to provide an efficient service, the unconscious bias of doctors, nurses and counselors will steer the woman in the direction favored by staff. What should be a free choice often isn't.

In other countries where a medical abortion service has been introduced, the total number of abortions has not increased, and this has been confirmed in New Zealand. In 2003, when medical abortion became more readily available, the number of abortions carried out that year was 18,510, and in 2015, the number had decreased to 13,155.

In its recently published annual report [3], the Abortion Supervisory Committee states: "The legislation that governs abortion law in New Zealand will be entering its 40th year since enactment in 1977. Over the last four decades, there have been significant changes to health care delivery as well as technological advancements in how we approach medicine."

It would make great sense to recommend changes in the law to make medical abortion more readily available as an important first step. Another change would be to take advantage of the trend for nurses to assume greater responsibility for sexual and reproductive health care.

Australia, by Paul Hyland

Medical abortion is the way of the future. Although restricted for political and religious reasons for many years, Australia's medical abortion rate is now increasing rapidly and will equal or soon overtake those in other Western liberal democracies. Given the choice, that's what women want. Its acceptability hinges on effective pain management and control of bleeding, as well as "around the clock" medical supervision to ensure that patients are adequately supported both physically and mentally throughout the process.

Simplification of the abortion process can be achieved while maintaining "best medical practice." The ultimate

method of providing this service is by supplying medications by mail for a home-based abortion, after telephone consultation — with no need for a face-to-face doctor visit.

Given appropriate informed choice, it is clear that most women will choose this convenient and less physically intrusive alternative. Unfortunately, in Australia, women are not offered, or indeed are dissuaded from medical abortion, because the facilities already in place provide a surgical rather than a medical procedure.

Despite the markedly lower cost of medical abortion, current service providers are defending their traditional methods and not encouraging the cheaper alternative. One can speculate that defending the "status quo" will only provide a brief respite from the inevitable redundancy of surgical facilities — along with reallocation of health funding, job and skill losses, and a renewed emphasis on education and early intervention.

Medical abortion is the way of the future for first-trimester abortion and indeed more so for gestations beyond 9 weeks. Governments will make the necessary adjustments — if the industry itself does not.

Spain, by Francisca García

In my opinion, the prior question here is: abortion in Spain — in the public health system? Without wanting to say anything negative about the health professionals who have been performing abortions in Spain for over 30 years, I would like to talk about some of the reasons why provision of abortion is not widespread in the public health system, and that the way in which abortion is gradually being incorporated into the public system in some autonomous communities is due to nothing other than the expansion of provision of medical abortion pills to the detriment of surgical methods. Yet I believe that both types of method are necessary and their co-existence essential to offering a quality abortion service that safeguards the privacy of women.

First, however, I think it is important to note that conscientious objection, the reason that has been identified historically as the main cause of the failure to provide abortion care in the public health system and which may well be true for the moral/ethical minority, has come to conceal the real and main reason. That is, that for public health professionals, it is none other than the stigma and loss of professional reputation that negatively affect those who perform abortions, and therefore, they are not willing to do them.

Little by little, however, I wonder whether the medical method of abortion has been reducing that stigma and opening up some cracks in the public system. Because this technique, which is both safe and effective, minimizes the involvement of the doctor in the abortion process; it is the woman, almost by herself, who brings on her own abortion, while the professional is limited to observing and monitoring, and intervening only if complications occur.

However, the lack of training for health professionals is another of the reasons for the non-assimilation of abortion in

the public health system. Today, the only kind of abortion that is included as a subject in the medical or nursing curriculum is spontaneous abortion, and abortion is not learned during medical specialization.

Which leads me to ask: Is the public health system prepared and willing to create specialist abortion units with committed professionals trained in all methods of induced abortion? And can they ensure the confidentiality, privacy and accompaniment women need during the process of abortion?

International health agencies point to the need for abortion providers to be trained for professional reasons in all the methods of abortion not only so that the woman can choose which method is best for her own health and circumstances (which cannot in all cases be resolved with the medical method) but also to ensure the safety of whichever intervention is used. If only the medical method is offered, it reduces the safety of the process in case something goes wrong, and it also reduces the right of women to decide what is best for them, including within their family circumstances. This is something that already happens in our neighboring countries, such as Portugal and France, where women have virtually no possibility to opt for the surgical method. Yet this is a technique that is chosen and preferred by more than 75% of women in Spain when women are given clear and impartial information about both methods.

ACAI (Asociación de Clínicas Acreditadas para la IVE) respects the desire for broader medical, political and social rights to be met by the public health system through provision of induced abortion. But we must add that this cannot in any way lead to a loss of safety, privacy and confidentiality for women. Otherwise, it could become a step backwards. Therefore, when evaluating whether the incorporation of induced abortion into the portfolio of public health services is taking place as it should do, we must focus not only on the provision of medical abortion, whose expansion benefits the pharmaceutical industry above all. The following questions are also relevant: Is there the will to create specialist units for induced abortion? Will professionals be trained in all abortion methods? Will women be offered all methods? Will women be able to choose a method according to their personal circumstances and health? Will women's privacy be protected? Will they have the necessary accompaniment?

If these questions have not even been asked by the public health administrators managing this process and have not been raised among the demands of the groups who are asking for this to happen, we can say without fear of contradiction that women may again be faced with experiencing abortion as a stigmatizing experience, devoid of attention and caring. It would not meet the quality indicators that women deserve [4].

Colombia, by Cristina Villarreal

A medication to induce abortion is something that women in Latin America have sought for years — it is the most

awaited pill. Women went, and, even today, go to pharmacies asking for something that will “bring on menstruation.” Before misoprostol, they just received concoctions, injections and tablets that only prolonged pregnancy without achieving the intended effect. Therefore, when Brazilian women discovered the abortifacient effects of misoprostol, this “secret” — shared by word of mouth — was well received by many other women in the region. It was then that prosecutions and restrictions on its distribution began. Nevertheless, women have always been resourceful and mutually supportive, and they continue to obtain the medications in different and creative ways. Unfortunately, prosecutions are increasing, especially for those women who self-use the medications.

Medications for abortion have two additional benefits. First, they reduce social injustice stemming from inequality of access to health services, and second, they compensate for the decrease in the number of abortion providers that we are seeing everywhere. In relation to the first benefit, there is still much to be done in Latin America to overcome the inequity barriers: mifepristone, the gold standard in combination with misoprostol for medical abortion, has not been available in the region, with the exception of Mexico and Uruguay, until now. Happily, it was announced by INVIMA (Instituto Nacional de Vigilancia de Medicamento) (the national drug regulator) in March 2017 [5] that mifepristone would become available in Colombia later in 2017. In most parts of Latin America, however, we are still having to rely on a less effective regimen because access to mifepristone is restricted by “moral” and administrative barriers.

Although the benefits I mention are real, it is only each individual woman who is facing an unwanted pregnancy who should have the right to decide how she wants to cope with the experience. Although some women are aware of the existence of medications and have the possibility of choosing them, they prefer the immediate certainty that other, surgical techniques provide. Thus, health systems and service providers are responsible for offering options to women so that they can be the ones to fully exercise their autonomy. Therefore, I believe that no one method for abortion should be the only method.

Brazil and México, by Aníbal Faúndes and Laura Miranda

The answer is different for developed countries than for those with restrictive abortion laws and rare or non-existent safe abortion provision in public hospitals. One problem is that while in the former group of countries the abortion stigma is minimal, in developing countries with restrictive abortion laws, the stigma is highly prevalent and has a great influence on the health professionals' behavior. In this latter group of countries, physicians are often not willing to provide surgical abortion but are more willing to prescribe medical abortion pills, which maintains a certain physical distance between themselves and the evacuation of the uterus [6].

The very positive effect of the availability of medical abortion has already been shown by the reduction of abortion complications and deaths after misoprostol became available in a growing number of those countries. More recently, when abortion on request up to 12 weeks of pregnancy became legal in Uruguay [7], safe, legal abortion became almost immediately universally available, thanks to the simultaneous registration of mifepristone and to having the mifepristone–misoprostol combination available in all public health services. Thus, the delay that would have been caused by having to train cadres of professionals in surgical abortion methods was avoided, and the eventual resistance of some physicians was also averted.

Medical abortion requires the back-up of services where a surgical procedure is available in case of incomplete abortion or bleeding for any cause, but such services are available because every gynecologist in Latin America has been trained in the use of curettage, and now of intrauterine aspiration, for the treatment of incomplete abortion. Thus, no additional training is needed. The training in the use of medical abortion is far simpler, and both general practitioners and nurses and midwives can easily be trained, broadening the cadres of health professional that can provide services and facilitating the provision of safe abortion services at primary health care level [8].

It is possible to foresee a future when women will be empowered to take a rapid decision when confronted with a delayed menses, purchasing and taking medication to “recover menses” without either the knowledge or intervention of anybody else — unless they wish it. The number of women currently self-inducing abortions, especially those using misoprostol alone, who are presenting at health facilities with “incomplete” or “complicated” abortions will

be greatly reduced, and women’s health will improve. We will also need to develop more non-provider-dependent, long-acting contraceptives, along the lines of the new self-injected subcutaneous depot medroxyprogesterone acetate [9], to provide women with the means to take all their own reproductive decisions.

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