

## Expanding access to medical abortion: challenges and opportunities

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Medical abortion using mifepristone and misoprostol (or misoprostol alone in settings where mifepristone has not yet been approved or made available) is a safe and effective method of terminating both early and later pregnancies. Misoprostol tablets can also be used to manage incomplete abortion and miscarriage. When used in early pregnancy, medical abortion can be provided at a primary care facility and by non-physician providers.<sup>1</sup> The over three decades long experience with these medications has also provided incremental evidence that many components of early medical abortion can safely take place outside of a facility setting as well, starting with women taking the mifepristone in the clinic and using the misoprostol at home, then also allowing the mifepristone to be taken at home. There are now various efforts going into helping women to check if the pregnancy is complete from home too, as the papers in this supplement show. As the evidence has accumulated, it is also reshaping our understanding and interpretation of the World Health Organization (WHO) definition of unsafe abortion, to account for the fact that “the persons, skills and medical standards considered safe in the provision of abortion are different for medical and surgical abortion”.<sup>2</sup>

Yet, translating global evidence into local reality remains challenging. Several of the papers in this supplement examine these barriers by studying the knowledge and perspectives of providers and women – both in contexts where legal abortion is restricted to only a few indications (e.g. Argentina, Zimbabwe) and in those that allow abortion on a broad range of grounds (e.g. Cambodia, India, Nepal, Turkey). Across these diverse settings, the common thread is the lack of accurate knowledge. The findings, taken collectively, indicate that scientifically accurate knowledge about medical abortion, appropriate regimes and management of

the process are not widespread – even in settings where medical abortion is legal and even among providers who are already providing medical abortion. Medical school curricula, even for ob-gyn students, do not always include medical abortion within the training. Across settings, reliable sources of information for providers, especially those working outside of large urban hospitals, remains limited, with the result that knowledge – even of evidence-based national guidelines – does not seem to percolate down to many providers or to influence their practice. Thus, use of obsolete methods, like sharp curettage, persists – as was noted in Colombia by Rodriguez et al and in Zimbabwe by Maternowska et al.

Similarly, whatever the legal setting, women do not have adequate information on the parameters of their countries’ laws, where and how to access legal and safe services or even where to access safe post-abortion care if they experience complications of unsafe abortion. Sources of accurate information are even more limited for rural and less educated women. Pharmacies, informal workers in the community, as well as the internet and hotlines, are often the only sources of information in settings where laws are restrictive, and as Ramos et al find in Argentina, the information that women can obtain from such sources is not always accurate or adequate to provide women with the counselling and support they want.

Resistance or reluctance to provide care among current or potential providers is a persistent challenge as well. For example, only 15% of medical students in Mihciokur’s study reported that they would provide medical abortion when they began practising medicine. On the other hand, physician resistance to expanding the pool of providers, to include other types of providers, can be strong, as was seen in Acharya and Kalyanwalla’s study in India. While their resistance may in part be

related to protecting professional turf, misconceptions and inaccurate knowledge about the safety of medical abortion also play a role.

Not all attitudes are negative, however; providers can be both knowledgeable and concerned about providing accurate information, as Petit et al found in Cambodia. And as numerous other papers in this supplement demonstrate, despite the challenges, it is possible to explore innovative approaches to facilitating access to information, decentralising medical abortion care and bringing it closer to women.

In settings where surgical abortion has been the only method of safe abortion used, introducing medical abortion as an option increases the potential to expand access to safe care. That this is both feasible and acceptable was shown by Louie et al in Armenia. Similarly Rob et al explored the feasibility of introducing medical abortion as part of Bangladesh's long-standing Menstrual Regulation (MR) programme. In partnership with the government, medical menstrual regulation services were successfully piloted in several rural and urban primary care facilities. The overwhelming majority of women had a successful MR without the need for a surgical intervention and the option was found to be acceptable to women as well as providers. Sanhueza and colleagues demonstrate that outpatient provision of medical abortion is possible even beyond nine weeks. Their study, within the context of Mexico City's legal abortion programme, successfully piloted this approach up to ten weeks (70 days).

While in both the Bangladesh and Mexico studies, the majority of women returned for a follow-up visit to the clinic to confirm the completeness of the abortion, such a visit is no longer considered mandatory. Numerous methods to help women assess completion of the abortion and whether there is a need for further follow-up are being researched. These include the use of low-sensitivity urine pregnancy tests and the use of a checklist of screening questions. Constant and colleagues take this a step further and into the realm of mHealth. In the context of urban South Africa, where cell phone penetration is high and women usually have private access to mobile phones, they demonstrate that using mobile-based interactive modes of asking screening questions is a possibility that merits further study.

Access can be increased further if non-physician providers are allowed to provide medical abortion.

In the Bangladesh study mentioned above, most of the providers at the public sector clinics were auxiliary workers. Puri et al in Nepal demonstrate that auxiliary nurse-midwives (ANMs) can independently and successfully provide medical abortion at even lower levels of care and even where there is no physician on site. Other community-based workers can play supportive roles by ensuring that women access the correct trained provider in a timely fashion or in facilitating referrals, as was also seen in the Puri et al study in Nepal.

Pharmacies remain a first point of contact for many women seeking a pregnancy termination method in settings where access to care is limited or not affordable. However, the information women receive from pharmacies is often inaccurate, and they are also often provided with inappropriate or ineffective medication. Interventions aimed at increasing knowledge or changing practice often show mixed success, as reported by Tamang et al in Nepal and Fetters et al in Zambia. Actual practice is hard to change in a one-off, short training course, and given the high turnover and heterogeneous background of pharmacy staff, repeated training is needed to sustain positive change.

While it is of benefit to women, medical abortion is cost-effective for health systems as well. In a case study in Colombia, Rodriguez and colleagues use decision-tree modelling to show that the health system could save costs by increasing existing medical abortion services and switching from sharp curettage to medical abortion. Sanhueza et al also argue that outpatient medical abortion extended to 70 days LMP will also lead to cost savings for public health services.

All of these approaches can help to bring care closer to women but as Subha Sri and Ravindran caution, it cannot be assumed that access to the medicines in and of itself corrects the underlying gender inequalities or the lack of autonomy within which women make their reproductive health decisions and become pregnant. These core issues need to be actively addressed, alongside efforts to improve access to safe abortion.

Most of the studies featured in this supplement were part of a research initiative on social science and operations research to expand access to medical abortion that was supported by the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) from 2009–2014 via a grant from an anonymous donor. These studies were selected competitively from

among research proposals that aimed to address a significant gap in their contexts and had the potential to result in programmatic or policy change. Findings from studies in this research initiative have also been reported in numerous other publications as well.

The need for operations or implementation research to keep pace with the ever rapidly advancing clinical evidence base on early medical abortion cannot be over-emphasised. For example, research trials have shown the safety and efficacy of providing early medical abortion in primary care outpatient settings with non-physician providers, but much still needs to be understood about how to ensure facilitative environments that make such task-sharing feasible within programme contexts. Similarly, determining the effectiveness or acceptability of the supportive roles of community-based workers in providing information and screening, ensuring early care-seeking and in providing support to women during the medical abortion, follow-up care and post-abortion contraception, remain areas of further research. Interventions with pharmacy workers can be challenging, yet finding effective strategies to improve their knowledge, information provision and referral abilities can be important elements in preventing unsafe abortion. As we have moved towards recognising that a follow-up visit may not be needed, we also need to develop simple tools for assessing completion of abortion that can be made available to women. Equally important is to find feasible ways to ensure that linkages to post-abortion contraception can be effectively made for women who do want it.

Counselling and information are the keys to a successful early medical abortion. Since it is a process that takes place in the woman's body, rather than a procedure that someone performs on the woman, the need for accurate information is a key for both the provider and the woman. Telemedicine, mHealth and use of non-traditional media are important avenues to explore, as are innovative training approaches for providers both within their curricula and as part of in-service training. Attention needs to be paid as well to strategies aimed at retention of trained providers, willing and able to provide care to the most rural

or marginalised women, as well as to young and single women.

Both successful and not so successful efforts need to be rigorously documented, as the paucity of monitoring and evaluation data continues to hamper efforts at scaling up and transferring lessons from one context to another.

Research findings are only the first step in bringing about programme and policy change. Attributing impact to the findings of a single study is difficult as most changes happen as a result of multiple factors. Dissemination of study results has to be followed by specific strategy and action related to translating the knowledge into implementation and advocating for change. Most of the researchers featured in this supplement have continued to work with their study findings and with others in their countries in order to effect such change. The work reported by Louie et al is a good example of how research supported the inclusion of first trimester medical abortion into reproductive health services for women in Armenia and led to a working group being convened which developed national guidelines on medical abortion provision based on the study's findings.

In conclusion, when faced with an unwanted or unintended pregnancy, women will continue to seek ways to end the pregnancy, safely or unsafely. While concerns about the unregulated use of these medicines may be valid, increasing availability through a graded scale-up that involves rationalization of procedures and providers and meets women's needs is the surest way to increase safety and safeguard against unregulated use. The vast evidence on the simplicity, safety and efficacy of medical abortion makes it ideally suited to expanding access to both safe abortion care and to care for post-abortion complications.

## References

1. World Health Organization. Safe Abortion: Technical and Policy Guidance for Health Systems. 2nd ed. Geneva: WHO, 2012.
2. Ganatra B, Tuncalp O, Johnston HB, et al. From concept to measurement: operationalizing WHO's definition of unsafe abortion. *Bulletin of World Health Organization* 2014;92(3):155. Doi: [10.2471/BLT.14.136333](https://doi.org/10.2471/BLT.14.136333).