

"Pills with Promise"

Traci Baird, AAP Board President and Senior Program Advisor at AAP partner organization Ipas, recently penned the lead article in A:

The Abortion Magazine. The article, "Pills with Promise," provides a concise overview of trends around medication abortion. It reads, "Medical abortion can expand women's access to safe abortion, but it has yet to reach all women."

"An American woman goes to her nearby Planned Parenthood clinic for an abortion. She learns that she has a choice between a medical abortion and a vacuum aspiration abortion. Based on what the counselor explains about the methods, she decides that the medical approach best suits her. She likes the idea that it resembles a miscarriage, and she feels fortunate that she had a choice. At the same time, in a small town in Mexico, where abortion is quite restricted by law, a woman goes to her local pharmacy where she gets tablets of misoprostol. She knows from the experiences of her cousin and her friend that the misoprostol will bring on her period, which is three weeks late. She feels fortunate that she did not have to resort to services by an unsafe provider. Both women, despite their very different legal, economic and social circumstances, have each achieved the potential of medical abortion (MA) — abortion with pills. According to the World Health Organization (WHO), more than 19 million unsafe abortions occur worldwide each year; 18.5 million of these occur in developing countries. While women from all socioeconomic levels may find it difficult to obtain safe abortion care in many countries, lack of access to safe care is most dire for poor, young and rural women in developing countries. Tragically, approximately 67,000 women die every year from unsafe abortion procedures. The problem is multifaceted: lack of education on preventing pregnancy, insufficient access to contraception, laws that restrict safe abortion services, social stigma, health-care providers with little or poor training and outdated technology all contribute. Unfortunately, safe methods, though they exist, are just not available to the vast majority of the world's women. Medical abortion (also called medication abortion and the abortion pill) consists of medicines used alone or in combination to halt pregnancy development and to cause a miscarriage. French researchers synthesized mifepristone in 1980 and started clinical testing shortly thereafter. Initial results with mifepristone by itself were underwhelming; combining the use of mifepristone with a prostaglandin, such as misoprostol, which causes the uterus to contract, unleashed its potential. Twenty years ago, in 1988, the medical abortion regimen was approved in France and the drug company, Roussel Uclaf, immediately faced pressure from anti-choice groups who threatened to boycott its other pharmaceutical products. Faced with this pressure the French Health Minister declared the medicine was "the moral property

of women” and insisted on its distribution. Mifepristone was also approved at that time in China, then in the United Kingdom in 1991, Sweden in 1992, and after years of debate, in the United States in September of 2000 (see article on p. 8). It is currently registered in about three dozen countries, including the European Union countries (except those with restrictive abortion laws, such as Ireland and Portugal), India, Russia, and — most recently — Nepal. Registration is underway in several others. The combination of mifepristone and misoprostol is remarkably safe and effective. When used within the first nine weeks of pregnancy 98 percent of women have a complete abortion without need for further intervention, and very few experience complications. In countries where mifepristone is not available — and even in some countries where it is registered but where it is very costly — women are increasingly turning to misoprostol by itself to cause an abortion. While not as effective as the combined regimen, misoprostol alone ends a pregnancy about 90 percent of the time (Faundes et al, 2007). Women for whom it doesn’t work can subsequently seek treatment for miscarriage or incomplete abortion, often without health-care providers seeing evidence of their previous intervention, which protects women in settings where abortion is a crime.

Changing the Abortion Landscape

Where abortion is legally restricted, the use of misoprostol — registered in many countries to treat gastric ulcers, and increasingly used for a full gamut of lifesaving obstetric indications — by women is changing the landscape of unsafe abortion. Women are increasingly gaining access to these medicines to use on their own, with information gleaned from friends, family, pharmacy workers, informal healthcare providers or the Internet. Instead of using sticks or caustic substances to end a pregnancy or seeking an unhygienic backstreet abortion, women use misoprostol. The drug is credited with reducing deaths and disabilities from unsafe abortion in Brazil, where it has the strongest and longest history of use on its own for abortion (Costa and Vessy, 1993; Faundes et al, 1996). Indeed, it has even changed how Brazilian women and gynecologists “view abortion and the willingness of health professionals to attend women with complications sympathetically,” wrote Margareth Arilha and Regina Maria Barbosa in *Reproductive Health Matters* in 1993 (vol. 1, no. 2). The promise for medical abortion is enormous. From a woman’s perspective, ending an unwanted pregnancy by swallowing some pills may seem almost too good to be true. The method is acceptable and desirable to women all over the world (Honkanen et al, 2004). Women who choose MA give many reasons for doing so, including the feeling that it’s more natural than an aspiration abortion, misoprostol can be taken at home (in many settings), and it affords greater privacy.

Expanding Access

Ideally, women would have a choice between medical and aspiration methods of abortion, but the remarkable potential of MA is its ability to be available and provided in communities where establishing aspiration services may be difficult. MA services do not require significant facility space, medical equipment or even providers trained in doing aspiration abortion. Although it is important that back-up aspiration services are available to women, they can be available at another location. In most countries where MA is officially available it is provided by

doctors or, in some settings, trained midwives. However, Ipas believes that a wide range of health-care providers — doctors, midwives, nurses, community health officers and others — could provide MA in community and local health centers. In many countries, especially those with large rural populations, women in remote areas will rarely, if ever, see a doctor or go to a large hospital. These women will only have full access to MA once it is available from midwives and local health workers and eventually in pharmacies. As we celebrate 20 years of mifepristone, we can look around the world at myriad successes in expanding women's access to this revolutionary abortion method. We must also look around the world and see the vast populations who have yet to benefit, and make it our priority to reach them. In this issue of A we examine the impact of MA and access to it around the world — from rural India to Uruguay to the United States.

Resources

Honkanen, H., et al. 2004. WHO multinational study of three misoprostol regimens after mifepristone for early medical abortion. *BJOG: an International Journal of Obstetrics and Gynaecology*. 111 (7): 715-725.

Costa, S.H. and M.P. Vessy, 1993. Misoprostol and illegal abortion in Rio De Janeiro, Brazil. *Lancet*, 341:1258-61.

Faundes A., Santos L.C., Carvalho M., Gras C. 1996. Post-abortion complications after interruption of pregnancy with misoprostol. *Studies in Family Planning*, 27(5).

Faundes A., C. Fiala, O.S. Tang and A. Velasco 2007. Misoprostol for the termination of pregnancy up to 12 completed weeks of pregnancy. *International Journal*"

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