

## Promote Access to the Full Range of Abortion Technologies: Remove Barriers to Medical Abortion

### WHAT IS MEDICAL ABORTION?

Medical abortion is an early, safe and effective alternative to surgical abortion that generally involves the use of two medicines to end a pregnancy. The most common regimen calls for an oral dose of mifepristone, a drug that blocks progesterone receptors and thereby detaches the embryo from the uterus, followed up to 48 hours later by a dose of misoprostol, a prostaglandin analog that causes uterine contractions in order to complete the abortion.<sup>4</sup> This regimen, which can be initiated as soon as pregnancy is confirmed,<sup>5</sup> is approximately 95% effective.<sup>6</sup> Most countries that have approved medical abortion regimens permit their use up to seven weeks gestation, with Sweden and the United Kingdom permitting medical abortion up to nine weeks into pregnancy.<sup>7</sup> Mifepristone, first approved for medical abortion in France in 1988, is also commonly known by its original French name, RU-486.<sup>8</sup>

Medical abortion should not be confused with emergency contraception (EC). While the function of medical abortion is to terminate pregnancy, that of EC is to prevent it. EC includes emergency contraceptive pills, which are generally taken within 72 hours of unprotected sex, and the copper-T intrauterine device, which may be inserted up to five days after unprotected sex.<sup>9</sup> While EC has been thought to prevent pregnancy in a variety of ways, depending on where a woman is in her menstrual cycle at the time she uses EC,<sup>10</sup> recent scientific research indicates that the most popular method of EC appears to work by preventing a woman from ovulating.<sup>11</sup> No form of EC is effective once implantation has begun, meaning that EC cannot interfere with an existing pregnancy.<sup>12</sup>

Women's right to the highest attainable standard of health<sup>1</sup> and their right to enjoy the benefits of scientific progress<sup>2</sup> entitle them to the full range of technologies for abortion care. Medical advancements have steadily improved the abortion technologies available to women. For example, vacuum aspiration's replacement of sharp curettage as the favored surgical abortion method has made the procedure considerably safer and more comfortable.<sup>3</sup> Introduction of a medical method of pregnancy termination gives women yet another option for safe, early abortion.

While laws on abortion vary throughout the world, nearly every country permits abortion under some circumstances. Even countries with restrictive abortion laws should therefore provide the full range of options—including medical abortion—for women legally entitled to terminate a pregnancy. Furthermore, medical abortion methods are being used in some countries without legal approval. To ensure that all women may access medical abortion in a safe setting with properly trained providers, governments should officially approve medical abortion regimens and remove barriers to the procedure.

## **MEDICAL ABORTION IS A SAFE, EFFECTIVE AND ACCEPTABLE ALTERNATIVE TO SURGICAL ABORTION**

In 2005, the World Health Organization (WHO) added Mifepristone and Misoprostol to its Model List of Essential Medicines,<sup>13</sup> a list intended to guide governments in their selection of necessary drugs for distribution through national health systems.<sup>14</sup> Mifepristone has been registered for use as medical abortion in at least 29 countries.<sup>15</sup> Studies of women and physicians in France, Great Britain and Sweden, where medical abortion with mifepristone has been registered for more than a decade,<sup>16</sup> provide ample evidence that the regimen is safe, effective and accepted by women:

- In general, medical abortion with mifepristone has consistently expanded in use since its introduction in each country.<sup>17</sup> According to recent estimates, about half of all abortions within approved gestational limits are performed medically in Scotland, Sweden, and Switzerland.<sup>18</sup>
- Since mifepristone was introduced, women who wish to terminate their pregnancies have started obtaining earlier abortions. Though the risks associated with a properly performed abortion are small, the earlier in pregnancy it occurs, the less likely there will be complications.<sup>19</sup> In France, where women may obtain medical abortion up to the seventh week of gestation, the proportion of abortions performed at or before that stage of pregnancy rose from 12% in 1987 to 20% in 1997.<sup>20</sup> In Sweden, where medical abortion is approved up to nine weeks' gestation, the proportion of abortions performed before that time increased from 45% in 1991 to 65% in 1999.<sup>21</sup>
- While opponents of choice predicted that the availability of medical abortion would lead more women to terminate their pregnancies, patterns in overall abortion rates suggest that these predictions are false.<sup>22</sup> In France and England and Wales, abortion rates did not change significantly from the year before mifepristone was approved to the most recent year for which data are available.<sup>23</sup> In Sweden, the abortion rate fell from 21 abortions per 1,000 women the year before mifepristone was approved to 18 per 1,000 nine years later.<sup>24</sup>
- Research on patients' evaluations of medical abortions found that the majority of women were satisfied with the procedure and would opt for the same method if a future termination were necessary.<sup>25</sup>

## **PROVIDING MEDICAL ABORTION PROMOTES SAFE ABORTION FOR MORE WOMEN**

Every year, nearly 70,000 women die and thousands more suffer permanent disabilities

## ***Remove Barriers to Medical Abortion***

as a result of unsafe abortion.<sup>26</sup> The availability of medical abortion can improve women's access to safe abortion services and thus help reduce abortion-related mortality and morbidity. As a safe method of pregnancy termination with the potential to reduce maternal health risks for thousands of women, medical abortion is an important component of reproductive health care to which all women are entitled.

- Because non-physicians can provide medical abortion, the availability of the method can help expand the pool of providers available to perform abortions.<sup>27</sup> Reducing reliance on physicians can reduce costs and help make abortion more available and accessible to women. In Great Britain, for example, nurses may administer the drugs as long as a physician prescribes them.<sup>28</sup> Similarly, in Sweden, physicians serve primarily as consultants and supervisors. They estimate the duration of pregnancy by ultrasound, but midwives are responsible for administering mifepristone and misoprostol, as well as counseling women.<sup>29</sup>
- Medical abortion can be provided in a variety of settings, including practitioners' private offices. Permitting medical abortion in a broad range of settings has the potential to increase the number of providers who will be willing to offer abortion services, thereby improving women's overall access to safe abortion.<sup>30</sup> Recently adopted regulations in France permit providers in licensed private medical offices, in addition to hospitals and clinics, to offer medical abortion.<sup>31</sup> Other countries, including South Africa and Tunisia, have pioneered home administration of misoprostol, the second dose of the medical abortion regimen.<sup>32</sup> Studies have shown that many women may prefer home administration of medical abortion, which would make the procedure more convenient, accessible and private.<sup>33</sup>

### **GOVERNMENTS SHOULD REMOVE BARRIERS TO MEDICAL ABORTION**

Medical abortion is the result of decades of medical research conducted to develop and perfect a safe alternative to surgical abortion. Governments should remove barriers to medical abortion and take steps to ensure women's access.

- ***Register mifepristone and misoprostol for use as medical abortion.***  
WHO has endorsed mifepristone and misoprostol as essential medicines.<sup>34</sup> The experience of millions of women has shown that administering these drugs is a safe and effective method of early abortion.
- ***Permit the broadest category of providers to offer medical abortion in the widest range of health care settings.***  
Where women have little or no access to physicians, medical abortion provided by non-physicians in a broad range of settings could significantly improve women's ability to undergo abortion safely.

• **Train providers.**

Training should cover not only how to provide mifepristone and misoprostol but also instruction on dating gestational age, identifying pregnancy abnormalities such as ectopic pregnancy, and determining the success of the procedure. Finally, all providers should be trained in appropriate counseling to precede and follow medical abortion.<sup>35</sup>

• **Ensure adequate funding.**

Medical abortion, like surgical abortion, should be funded no differently than other medical procedures. Furthermore, where public funding is available for abortion, financial disincentives should not be used to discourage providers from offering medical abortion. This happened in Germany, where the public health insurance administration set the rate of reimbursement for medical abortion well below the cost of the necessary office visits. As a result, many providers do not offer medical abortion in Germany or provide it only to women who pay for the procedure themselves.<sup>36</sup>

• **Remove procedural barriers.**

Pursuant to their general abortion laws, some countries impose mandatory counseling or a waiting period—or both—before a woman takes her first dose of mifepristone. In France, for example, women must wait seven days before they can obtain a medical or surgical abortion.<sup>37</sup> Because safe and effective medical abortions are limited to the first few weeks of pregnancy, the delays caused by such restrictions can reduce the number of women eligible for the method.

**Countries where mifepristone is registered for use as medical abortion include:**<sup>38</sup>

Austria	India	Sweden
Azerbaijan	Israel	Switzerland
Belgium	Latvia	Taiwan
China	Luxembourg	Tunisia
Denmark	The Netherlands	United Kingdom
Finland	New Zealand	Ukraine
France	Norway	United States
Georgia	Russia	Uzbekistan
Germany	South Africa	Vietnam
Greece	Spain	

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**ACKNOWLEDGEMENT**

*The Center for Reproductive Rights is grateful for the input of Dr. Christian Fiala, Gynmed Ambulatorium, Vienna, Austria, who provided valuable information on the status of medical abortion in Europe. The Center is solely responsible for errors or omissions in this briefing paper.*

**ENDNOTES**

- 1 International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, at 49, U.N. Doc A/6316 (1966), art. 12, 999 U.N.T.S. 3 (entered into force Jan. 3, 1976).
- 2 *Id.* art. 15.
- 3 WORLD HEALTH ORGANIZATION (WHO), SAFE ABORTION: TECHNICAL AND POLICY GUIDELINES FOR HEALTH SYSTEMS 32-33 (2003) [hereinafter WHO, TECHNICAL AND POLICY GUIDELINES], available at [http://www.who.int/reproductive-health/publications/safe\\_abortion/safe\\_abortion.pdf](http://www.who.int/reproductive-health/publications/safe_abortion/safe_abortion.pdf).
- 4 GYNUITY HEALTH PROJECTS, PROVIDING MEDICAL ABORTION IN DEVELOPING COUNTRIES: AN INTRODUCTORY GUIDEBOOK 3, 13 (2004), available at [http://www.gynuity.org/documents/guidebook\\_eng\\_005.pdf](http://www.gynuity.org/documents/guidebook_eng_005.pdf).
- 5 IPAS, MEDICAL ABORTION – IMPLICATIONS FOR AFRICA 4 (2003), available at [http://www.ipas.org/publications/en/Medical\\_Abortion/med\\_ab\\_africa\\_web\\_only\\_en.pdf](http://www.ipas.org/publications/en/Medical_Abortion/med_ab_africa_web_only_en.pdf).
- 6 GYNUITY HEALTH PROJECTS, *supra* note 4, at 4.
- 7 *Id.* at 11.
- 8 *Id.* at 1.
- 9 International Consortium for Emergency Contraception (ICEC), *What is Emergency Contraception?*, at <http://www.cecinfo.org/html/fea-what-is-ec.htm> (last visited Aug. 8, 2005).
- 10 ICEC, *Policy Statement on Mechanism of Action: How do Emergency Contraceptive Pills Work to Prevent Pregnancy?* (July 2003), at <http://www.cecinfo.org/files/ICEC%20-%20Mechanism%20of%20Action%20Policy%20Statement%202003.pdf>. EC has been reported to prevent pregnancy by inhibiting ovulation, blocking fertilization, or preventing implantation of the fertilized egg in the uterus. *Id.*
- 11 *Emergency Contraception's Mode of Action Clarified*, POPULATION BRIEFS: REPORTS ON POPULATION COUNCIL RESEARCH (Population Council, May 2005, Vol. 11, no. 2), available at [http://www.popcouncil.org/publications/popbriefs/pb11\(2\)\\_3.html](http://www.popcouncil.org/publications/popbriefs/pb11(2)_3.html).
- 12 ICEC, *Policy Statement on Mechanism of Action: How do Emergency Contraceptive Pills Work to Prevent Pregnancy?*, *supra* note 10.
- 13 WHO, ESSENTIAL MEDICINES, WHO MODEL LIST 20 (14th Edition, revised March 2005) [hereinafter WHO, ESSENTIAL MEDICINES], available at <http://whqlibdoc.who.int/hq/2005/a87017.pdf>.
- 14 WHO, *Essential Drugs and Medicines Policy: What are Essential Drugs?* (last updated July 4, 2005), at <http://www.who.int/medicines/rationale.shtml>.
- 15 Ipas, *Medication Abortion – Frequently Asked Questions*, at [http://www.ipas.org/english/womens\\_health/abortion\\_methods/medication\\_abortion.asp](http://www.ipas.org/english/womens_health/abortion_methods/medication_abortion.asp) (last visited Aug. 10, 2005) [hereinafter Ipas, *Medication Abortion FAQ*].
- 16 Mifepristone was registered for use as an abortifacient in 1988 in France, 1991 in Great Britain and 1992 in Sweden. Rachel K. Jones & Stanley K. Henshaw, *Mifepristone for Early Medical Abortion: Experiences in France, Great Britain and Sweden*, 34(3) PERSPECTIVES ON SEXUAL & REPRODUCTIVE HEALTH 154 (2002).
- 17 Elizabeth Pirruccello Newhall & Beverly Winikoff, *Abortion with Mifepristone and Misoprostol: Regimens, Efficacy, Acceptability and Future Directions*, 183(2) AMERICAN JOURNAL OF OBSTETRICS & GYNECOLOGY S44-S53 (2000).
- 18 Christian Fiala, Gynmed Ambulatorium, Vienna, Austria, *Abortion Methods – European Issues* (presentation abstract), European Society of Contraception (ESC), *Abstracts of the 8<sup>th</sup> ESC Conference Edinburgh 2004*, at [http://www.contraception-esc.com/congress/abstracts/state\\_of\\_the\\_art.htm#Session%204:%20Abortion](http://www.contraception-esc.com/congress/abstracts/state_of_the_art.htm#Session%204:%20Abortion); accompanying graphic provided by the author, Dec. 25, 2004 (on file with Center for Reproductive Rights).
- 19 WHO, TECHNICAL AND POLICY GUIDELINES, *supra* note 3, at 23.
- 20 Jones & Henshaw, *supra* note 16, at 156.
- 21 *Id.*
- 22 *Id.*
- 23 *Id.* The abortion rate in France for women aged 15-44 was 13 abortions per 1,000 women in 1987 and 1997, and 16 per 1,000 in 1990 and 2000 in England and Wales. *Id.*
- 24 *Id.*
- 25 *Id.* at 159; see also Beverly Winikoff, *Acceptability of Medical Abortion In Early Pregnancy*, 27(4) FAMILY PLANNING PERSPECTIVES 142 (1995).
- 26 WHO, UNSAFE ABORTION 14 (2004), available at [http://www.who.int/reproductive-health/publications/unsafe\\_abortion\\_estimates\\_04/estimates.pdf](http://www.who.int/reproductive-health/publications/unsafe_abortion_estimates_04/estimates.pdf).

- 27 See GYNUITY HEALTH PROJECTS, *supra* note 4, at 32.
- 28 Jones & Henshaw, *supra* note 16, at 157.
- 29 Ipas, *Deciding Women's Lives are Worth Saving: Expanding the Role of Midlevel Providers in Safe Abortion Care*, ISSUES IN ABORTION CARE 7 at 15 (2001), available at [http://www.ipas.org/publications/en/issues\\_in\\_abortion\\_care/I7\\_E02\\_en.pdf](http://www.ipas.org/publications/en/issues_in_abortion_care/I7_E02_en.pdf).
- 30 Bonnie Scott Jones & Simon Heller, *Providing Medical Abortion: Legal Issues of Relevance to Providers*, 55(3) JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION 145 (2000), available at [http://www.reproductiverights.org/pub\\_art\\_amwaprov.html](http://www.reproductiverights.org/pub_art_amwaprov.html).
- 31 France, Decree no. 2001-636 of July 1, 2004, art. 1, PUBLIC HEALTH CODE (NEW REGULATORY PART), arts. R2212-9 – R2211-19, available at <http://www.legifrance.gouv.fr/WAspad/VisuArticleCode?commun=CSANPU&code=&h0=CSANPUNR.rcv&h1=2&h3=48>; see also, Service-Public, *Vos Droits et Démarches: Santé, Interruption volontaire de grossesse*, available at <http://vosdroits.service-public.fr/particuliers/F1551.xhtml?&n=Sant%C3%A9&l=N17&n=IVG,%20contraception&l=N435#titreN100F0>.
- 32 See IPAS, *supra* note 5, at 6.
- 33 Newhall & Winikoff, *supra* note 17, at S44-S53.
- 34 WHO, ESSENTIAL MEDICINES, *supra* note 13, at 20.
- 35 See GYNUITY HEALTH PROJECTS, *supra* note 4, at 27-28.
- 36 Elke Thoss & Joachim von Baross, *Mifegyne in Germany: Were All the Efforts in Vain?*, 28(2) CHOICES 26-28 (2000).
- 37 France, PUBLIC HEALTH CODE (NEW LEGISLATIVE PART), art. L2212-5 (2005), available at <http://www.legifrance.gouv.fr/WAspad/RechercheSimplePartieCode?commun=CSANPU&code=CSANPUNL.rcv#>.
- 38 Ipas, *Medication Abortion FAQ*, *supra* note 15.