

FIAPAC 2012

Increasing Access to Safe Abortion Services

Kristina Gemzell Danielsson, prof, MD, PhD
Director of the WHO CCR in Human Reproduction,
Chair, Division of Obstetrics & Gynecology,
Department of Women's and Children's Health,
Karolinska Institutet / Karolinska University Hospital
Stockholm, Sweden



"Women are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving."

Professor M.F. Fathalla

Former President of the International Federation of Gynaecology and Obstetrics

Professor of Obstetrics and Gynaecology, Assiut University, Egypt

Who decides over fertility?



US-president Bush signing a law against late abortions, 2003



Goal 5

Improve maternal health

TARGET

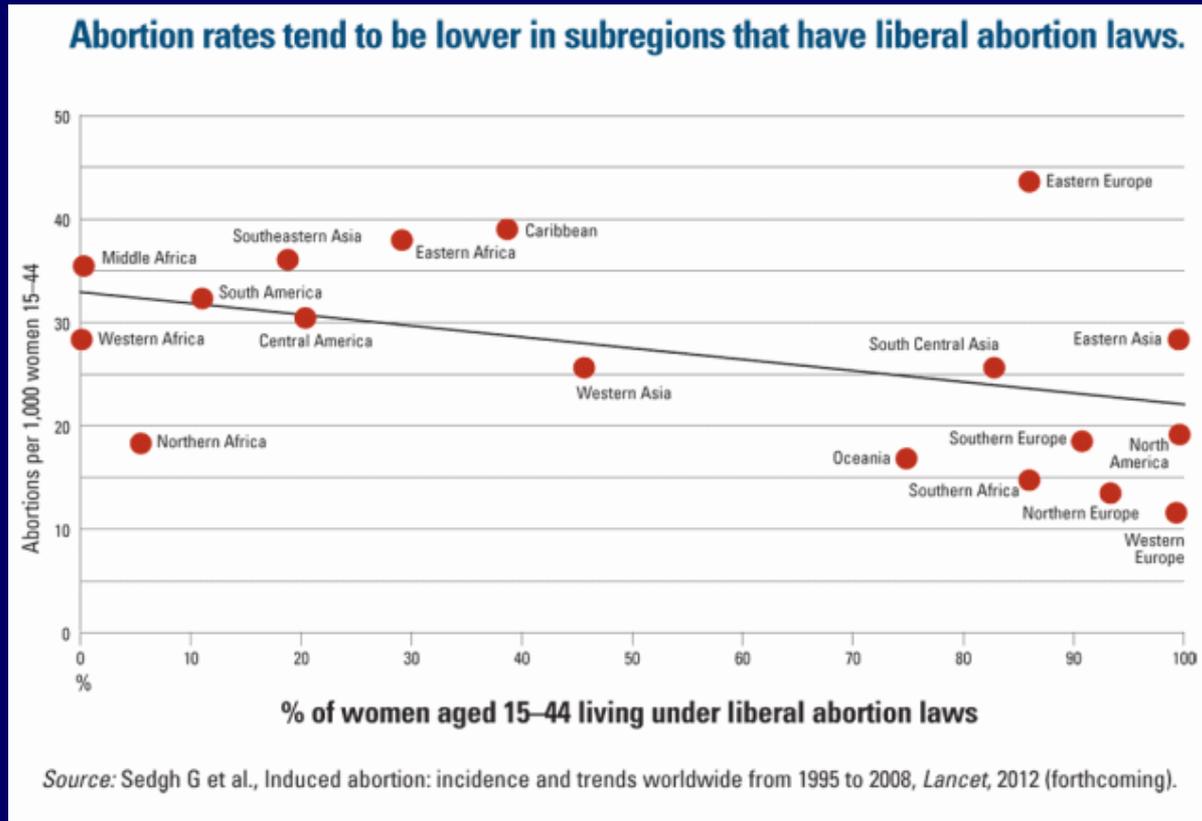
Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

Achieving good maternal health requires quality reproductive health services and a series of well-timed interventions to ensure a women's safe passage to motherhood. Failure to provide these results in hundreds of thousands of needless deaths each year—a sad reminder of the low status accorded to women in many societies.

Measuring maternal mortality—death resulting from the complications of pregnancy or childbirth—is challenging at best. Systematic underreporting and misreporting are common, and estimates lie within large ranges of uncertainty. Nevertheless, an acceleration in the provision of maternal and reproductive health services to women in all regions, along with positive trend data on maternal mortality and morbidity, suggest that the world is making some progress on MDG 5.



Abortion rates and abortion laws



Sedgh G et al., *Lancet* 2012

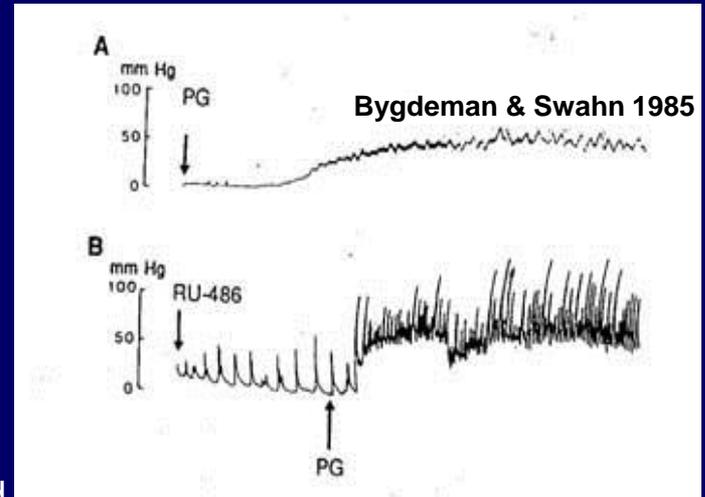
Abortion related deaths can be prevented !!!!

- Recognize abortion as a major contributor to maternal mortality
 - Politicians, doctors, nurses (FIGO), the Church etc.
- **Increase access to safe abortion methods and stop outdated methods-** Vacuum aspiration (MVA), medical abortion, misoprostol, "menstrual regulation", PAC
- Increase emergency service for abortion related complications
 - Midlevel providers, doctors, MVA, drugs
- Contraceptive counselling and contraception also for young and unmarried women
- Information on sexual and reproductive health and rights
- Empower women!

Development of medical abortion

- 70ies, Prostaglandin analogues, High efficacy, High incidence of side effects
- 80ies, Mifepristone (RU 486, Roussel Uclaf), 60-80 % efficacy Herrman et al., 1982, Kovacs et al., 1984
- 1985; Mifepristone increases uterine contractility and sensitivity to PG
- 1986 Mife+ Gemeprost Cameron, Michie, Baird
- 1991 Mife+ oral misoprostol Norman, Thong, Baird
- 1995 Vaginal misoprostol more effective than oral El Rafaey..., Templeton
- Medical abortion Mifepristone followed by PG:

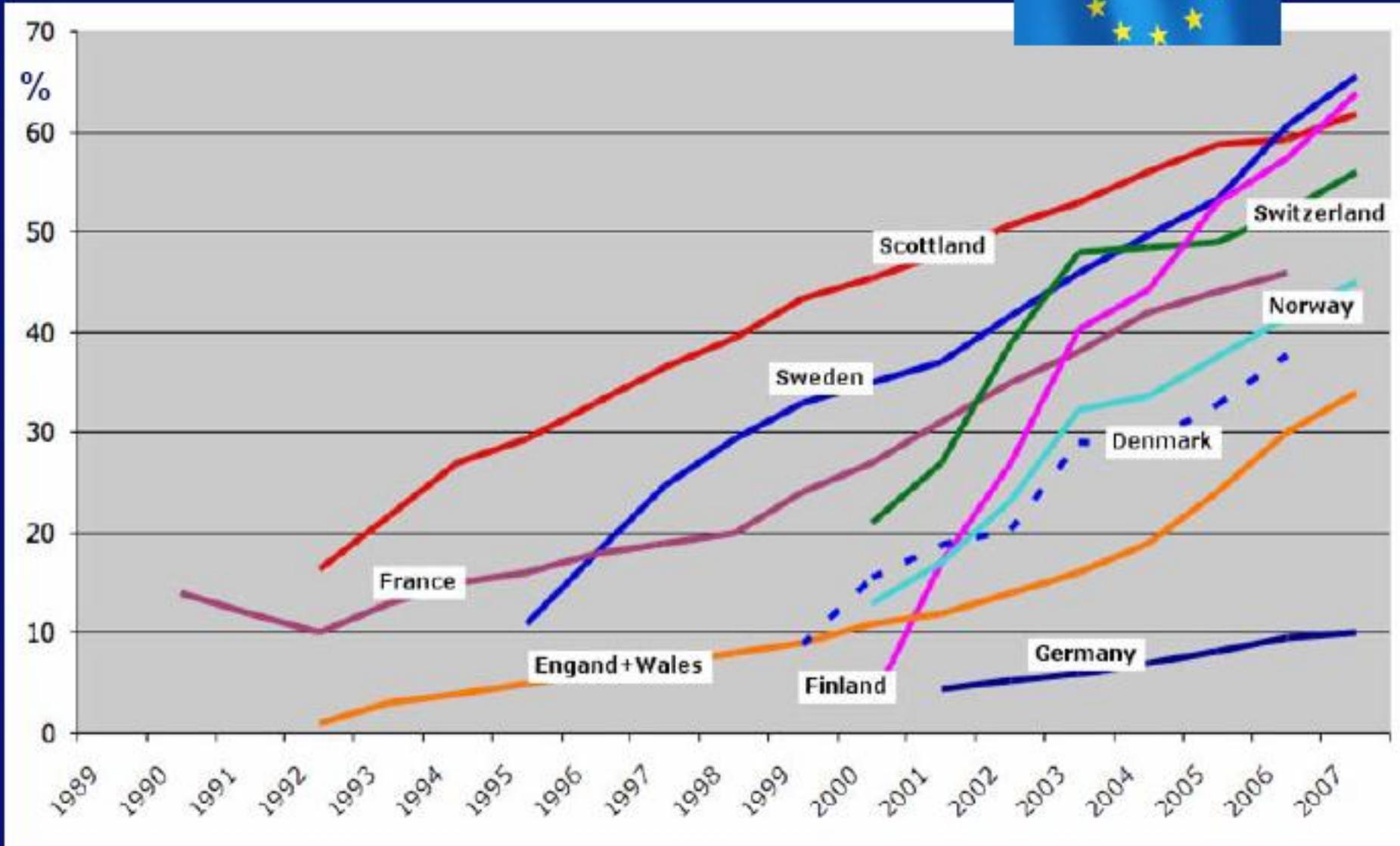
1988 France	49d., 400 mg Cytotec®
1991 UK	63d. 1mg gemeprost
(1992 China	49d., 600 mg Cytotec®)
1992 Sweden	63d., 1mg gemeprost



Medical Abortion protocol in Sweden 1990ies →

- **Telephone booking**
- **Visit 1** Attend abortion Clinic; visit to gynecologist and midwife
 - Counseling and clinical assessment of gestation
 - Screening for STI (chlamydia)
 - Contraceptive counseling and prescription
- **Visit 2**
 - **Mifepristone (600→200)**
- **Visit 3** (36-48 hrs after mifepristone)
 - **PG (gemeprost→misoprostol)**
 - Pain relief
 - Stay at clinic 4-6 hrs
- **Visit 4** (Follow-up) (gynecologist→ midwife)
 - 3 weeks: pelvic examination, US, hCG

Proportion of medication abortions (first trimester)

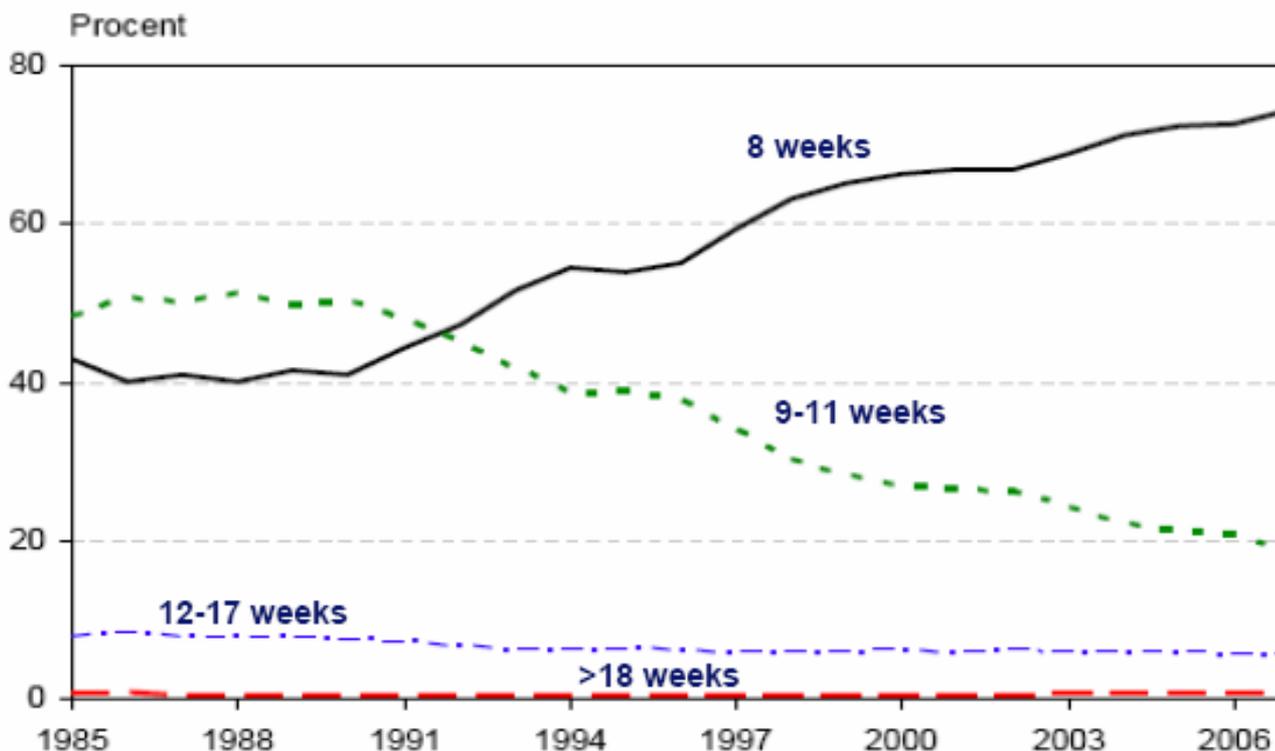


Increased access to safe abortion. K.Gemzell

Impact of reducing barriers in access

Diagram 4. *Andel (%) verkställda aborter efter graviditetens längd 1985–2007*

Proportion (%) of induced abortions by duration of gestation 1985–2007



Sweden 2011: approx.90% of abortions up to 63 days are medical

Medical abortion

- Highly effective, safe and acceptable method
- Can be used for all gestational lengths
- Can replace surgical abortion
- Mifepristone – Limited approval. Available in about 53 countries, Expensive
- Misoprostol– alone highly effective (FIGO guidelines) but priming with mifepristone increases efficacy, allows lower dose and less side effects

**How can we increase access
to medical abortion
with the most effective regimen?**

How can we increase access to medical abortion with the most effective regimen?

1. Home use of (mifepristone) + misoprostol
2. Telemedicine
3. Task - shift / - sharing
4. Simplified procedures for FU

1. Home use of misoprostol up to 63 days

- Safety and acceptability established in a number of studies
- Reasons to choose home-use of misoprostol
 - Easier
 - More private
 - Feels more comfortable with a heavy bleeding at home
- Home use an option in Sweden since 2004
(approved by the Board of Health and Welfare)
- 99 % would have preferred to take mifepristone at home

Fiala et al., 2004, Kopp-Kallner et al., 2010

Using telemedicine for termination of pregnancy with mifepristone and misoprostol in settings where there is no access to safe services

RJ Gomperts,^a K Jelinska,^b S Davies,^c K Gemzell-Danielsson,^d G Kleiverda^e

^aWomen on Waves, Amsterdam, the Netherlands ^bWomen's Wallet, Amsterdam, the Netherlands ^cWomen on Web, Minneapolis, MN, USA ^dDepartment of Woman and Child Health, Karolinska Institutet, Stockholm, Sweden ^eDepartment of Obstetrics and Gynaecology, Flevoziekenhuis, Almere, the Netherlands

Correspondence: RJ Gomperts, Women on Waves, PO Box 15683, 1001 ND, Amsterdam, the Netherlands. Email gomperts@womenonwaves.org

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Women on Web is a service that uses telemedicine to help women access mifepristone and misoprostol in countries with no safe care for termination of pregnancy (TOP). This study reviews the telemedicine service. After an online consultation, women with an unwanted pregnancy of up to 9 weeks are referred to a doctor. If there are no contraindications, a medical TOP is conducted by mail. After maximising the follow up from 54.8 to 77.6%, 12.6%

decided not to do the TOP and 6.8% of the women who did the medical TOP at home needed a vacuum aspiration. Telemedicine can provide an alternative to unsafe TOP. Outcomes of care are in the same range as TOP provided in outpatient settings.

Keywords Abortion, buccal misoprostol, e-health, home-use, mifepristone, self-administration, telemedicine.

www.womenonweb.org

I need an abortion



Do you have an unwanted pregnancy? Click here. This online medical abortion service helps women gain access to a safe abortion with pills in order to reduce the number of deaths due

I had an abortion



Every year 42 million women have an abortion. Every 7 minutes a woman dies unnecessarily from an illegal abortion. Show your face, share your story, donate your money and help women around the world get access to safe abortions. Discuss and share information with others. Look for support if you are considering an abortion. Participate to support abortion rights, also if you did not have an abortion. Click on one of the portraits to find our more....

3. Task sharing: Medical abortion provided by physician or midwife

- RCT at the Karolinska University Hospital to assess the feasibility and acceptability of medical abortion up to 63 days' gestation when used in clinical routine
- provided by either midwife or gynecologist
- Training prior to the study incl basic knowledge on induced abortion, knowledge on ultrasound examination and treatment regimens, theoretical and practical)

Kopp Kallner, Gomperts et al.,

Medical abortion provided by physician or midwife

- Midlevel provision of medical abortion in Nepal – no difference in efficacy compared with physician

Warrener I et al., 2010

- Main differences:
- No selection of patients, Randomised at booking
- Examination incl. gynecological ultrasound

Results I

- 2011 01 31. LPLV 2012 07 25.
- 1071 patienter randomised ; 534 (midwife) and 533 (dr)
- 133 (12,4%) lost to follow up. →938 patients
- No differences were found with regard to:
 - Demographic parameters
 - Acceptability
 - "How well informed"
 - "Feeling safe"
 - No of unscheduled visits or surgical interventions
-

Results II - differences

- More women randomised to a physician chose home administration of misoprostol $p=0.029$
- Midwives providers prescribed significantly more LARC vs. physicians ($p= 0.004$)
- Time for the consultation was significantly shorter for midwives vs. physicians $p<0.01$.
- Significantly more patients would prefer to see a midwife in case of a future abortion

4. Simplified Follow Up in medical abortion: routine vs. self assessment

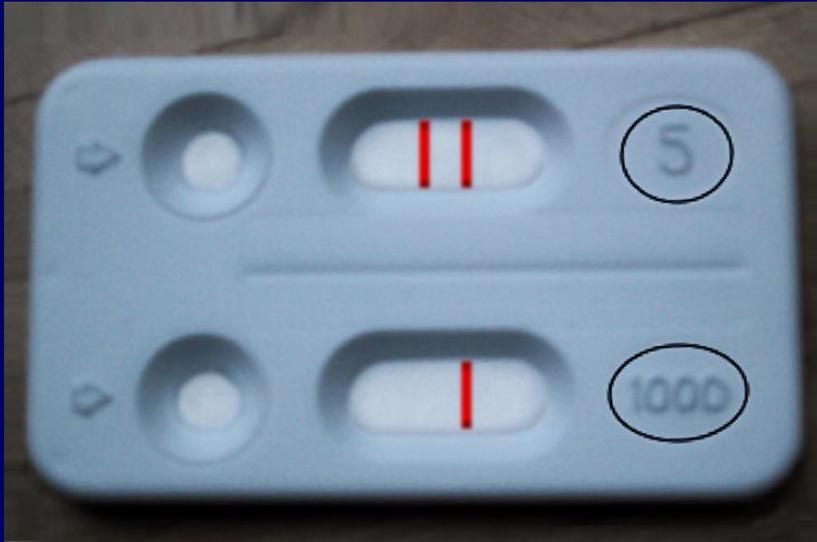
Rational.

- Low rate of FU after medical abortion
- Only reason for FU to detect an continuing viable pregnancy
- s-hCG most effective, limitations, good corelation with u-hCG

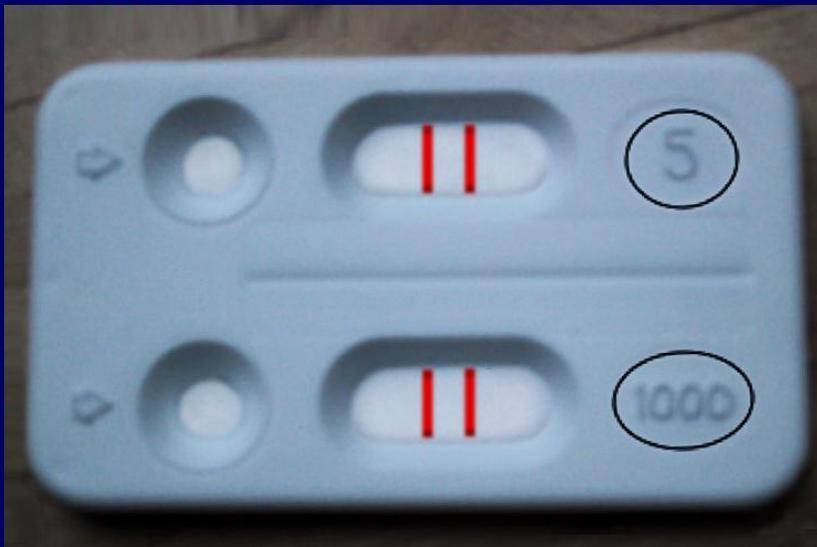
Design.

- RCT multinational, multicentre trial
- to assess the feasibility, efficacy and acceptability of self evaluation of complete abortion vs. clinical routine in medical abortion up to 63 days' gestation using a low sensitivity u-hCG test
- 1200 women admitted for medical abortion with home use of misoprostol

Home self test



Complete abortion



**Incomplete abortion
or failed test → 'Call the Clinic**
Increased access to safe abortion. K.Gemzell

Checklist MA Home Assessment

Check the box when the answer is YES

Complete abortion (when 2 or more):

- Did you see expulsion of products?
- If you had any pregnancy symptoms before, are they gone?
- Did the pregnancy test (1000) show negative?



Incomplete abortion/complications (when 1 or more):

- Are you still bleeding?
 - If **yes**, more than a normal period?
- Do you have severe abdominal cramps?
- Did the pregnancy test (1000) show positive?
- Do you feel sick?
 - Have you had a fever?
 - Have you had prolonged abdominal pain?
- Do you have excessive blood loss?
- Do you feel weak/ the whole body is aching?



**Contact
the clinic**

Results, interim analysis

- No difference in efficacy (complete abortions) and safety.
- Significantly more women were lost to FU in the control group (29%) vs. the intervention group (n=1) ($p < 0.001$)
- 92% found the home self test easy to use.
- 92% in the intervention group preferred self-assessment vs. 54% in the control group in case of a future abortion

- Same test found to be feasible and acceptable in clinical routine (Cameron ST, Glasier A et al., Contraception, 2012)

Medical abortion; "one stop clinic"

Karolinska University Hospital 2012

- Telefon booking
- Visit 1 on Day 1 to midwife or gynecologist; counseling, examination, contraceptive provision,
- mifepristone 200 mg taken in the clinic
- 24-48 h later: Cytotec 800 mcg, at home, pain medication
- FU at 1- 2 weeks. u-hCG self test

- Women can chose between:
 - surgical or medical abortion
 - misoprostol at home or in the clinic
 - FU in the clinic or self assesement

Conclusion

- Increased access to safe abortion services can be achieved by expanding access to medical abortion through:
 - Home use of (mifepristone)/ misoprostol
 - Telemedicine which can provide an alternative to unsafe abortion
 - Task shift/sharing with midlevel providers
 - Home self assessment with a check list and low sensitivity U-hCG

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