

Defining access abortion restricted



- Law on abortion restricted.
- Approval and registration of drugs absent.
- Importation and cost of drugs uncontrolled.
- Pharmacy/black market availability -self-use often.
- Health system incorporation of abortion provision -in secret, focused on complications - public vs. private
- Training in providing method(s) haphazard, experiential, lack of information
- Women ill-informed about method, availability,

Defining access -



- Approval and registration of drugs
- Importation and cost of drugs for health system,
- Health system incorporation of abortion provision -primary, secondary, tertiary -public vs. private
- Training in providing method(s) for first and second trimester abortions for appropriate cadres
- Women informed about method, availability and know others who have used it.

Lag time: development and promotion to access



- Family planning -modern methods increase in use averaged about 1.4% more per year in 20th centurv*
- Condom use -young, single women in Africa also about 1.4% per year*
- PMTCT -10% globally after a decade**
- Cervical cancer screening patchy
- HPV vaccine universal coverage goal but…

*Cleland et al. RHM 2006:14(28). ****PMTCT** Symposium. Toronto. AIDS 2006.

Lag time to seek/get abortion

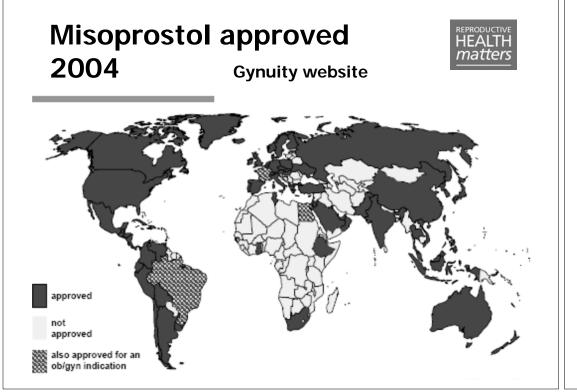


- Biggest advantage of medical abortion is how early in pregnancy it can be used with high efficacy.
- Delays in woman recognising and confirming pregnancy need to be reduced.
- Delays in woman being able to access a clinic or get the drugs herself.
- Calls for re-education of providers, including pharmacists, and women, to make optimal usage possible.





1988	China, France 1989 UK 1992 Sweden
1999	Austria, Belgium, Denmark, Finland,
Germ	any, Greece, Israel, Luxembourg,
Neth	erlands, Spain, Switzerland
2000	Norway, Russia, Taiwan, Tunisia, Ukraine,
USA	
2001	New Zealand, South Africa
2002	Azerbaijan, Belarus, Georgia, India, Latvia,
	Uzbekistan, Vietnam
2003	Estonia
2004	Guyana, Moldova
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Specific "complications": legal medical abortion



- Three drug combinations mifepristone + PG, methotrexate + PG or PG alone — with a confusing jumble of dosages and regimens at different stages of pregnancy.
- Differences in type of provider and aspects of care, e.g. vaginal or oral PG, home or clinic, ultrasound, number of visits, dealing with incompletes, etc.
- Differences among abortion providers as to what is "the preferred method", e.g. surgical or medical after 9 weeks of pregnancy and in the second trimester.

Specific "complications": legally restricted abortion



- Indiscriminate use, large doses, late use. (Caribbean)
- Instructions for providers, chemists, women not available. (Latin America)
- Incorrect regimens used, even with plethora of regimens.
- Concern and uncertainty whether bleeding is normal or not, abortion complete or not. (India)
- Distinctions between effective and ineffective "medical methods" not made by chemists. (India)
- No one responsible except the woman.

Improving access



- Patience and persistence in seeking approval and setting up services — time lags are inevitable.
- Consensus on terminology.
- Simplicity and greatly reduced anarchy re dosages, regimens, aspects of care, etc.
- Choice of method or choice between clinics offering one or other method, through second trimester.
- Low-cost drugs and public sector prices.
- Private sector (non-proft) provision as a form of advocacy for public sector provision.
- Information based on practice that most women

Too often…



Further reading



The abortion pill

Reproductive Health Matters. Vol.13 No. 26 November 2005

Articles on access and acceptability from: South Africa, Caribbean, India, Mexico, Colombia, Ecuador, Peru, Moldova, Turkey and Nepal

