Ibis Reproductive Health

Medication Abortion

Brief 2: Strategies for improving service delivery and access to services

Brief

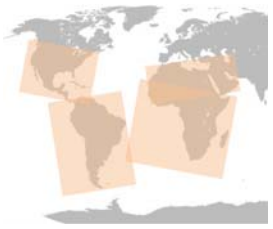
Highlights

- An innovative telemedicine system for dispensing medication abortion in the United States has the potential to improve access to abortion for women living in states where only physicians are allowed to provide abortions. Ibis evaluated this cutting-edge project in the state of Iowa.
- Ibis supports providers and policymakers in South Africa working to improve the quality of second-trimester abortion services and to integrate medication abortion into public-sector abortion services.
- Ibis's research on the knowledge, opinions, training, and practices of health care providers and pharmacists in various regions has identified strategies and opportunities for expanding access to abortion through provider education.

Ibis Reproductive Health aims to improve access to medication abortion for women around the world. Using clinical and social science research, we test ways to make protocols and regimens—including both mifepristone and misoprostol and misoprostol-alone options—more user friendly; explore ways to improve access to medication abortion services and service delivery; and examine global policy related to medication abortion. We also strive to improve access to medication abortion by providing medically accurate information about this service to diverse audiences. We work in many different contexts, including where abortion is legal and where it is restricted, low-resource settings, and places where rates of unsafe abortion are high.

Where we work

Ibis works in a number of countries in diverse contexts, including in Latin America and the Caribbean, the Middle East and North Africa, sub-Saharan Africa, and the United States. In this brief, we feature work done in the United States, South Africa, several countries in Latin America, and Palestine.



United States

Evaluating innovative models of service delivery: The telemedicine system

Many states in the US, like Iowa, permit only physicians to provide abortions. To address this barrier, Planned Parenthood of the Heartland has developed a new technology—a telemedicine system referred to as a "lock-box"—that allows physicians to dispense mifepristone and misoprostol to women from a remote location. Under the physician's observation through an internet video connection, the patient removes the drugs from the lock-box and ingests the mifepristone. In collaboration with the Abortion Access Project and Planned Parenthood of the Heartland, we evaluated this project with the goal of creating information that can be used by other provider networks nationwide to replicate this model and increase access to abortion, particularly in remote areas with no abortion providers. Preliminary results from a prospective study comparing 221 telemedicine clients and 223 standard provision clients at similar gestational ages found similar efficacy and adverse event rates in both groups. Telemedicine clients were significantly more likely than standard provision clients to have an appointment sooner from the time they called (7.6 vs. 10 days), and more telemedicine clients reported being very satisfied with the service (94% vs. 88%) and said they would recommend it to a friend (90% vs. 82%). Of telemedicine clients, 99% said it was easy to see and hear the doctor; 89% felt comfortable asking questions, while 25% would have preferred being in the room with the physician. In conclusion, this telemedicine provision model is at least as safe, effective, and acceptable as the standard model and is a reasonable alternative for providing medication abortion at sites with no onsite physician.

Highlighting the need for provider education: Curricular reform in ob/gyn residency programs

The availability of abortion training in ob/gyn residency programs and the decisions of residents to avail themselves of the training and eventually provide abortion services are critical to ensuring continued access to safe and legal abortion in the US. With input from Physicians for Reproductive Choice and Health, Ibis completed a study that examined abortion training in US ob/gyn residency programs. The study was comprised of three components: 1) a content analysis of 246 ob/gyn residency program websites to examine how abortion training opportunities were described; 2) in-depth interviews with 36 physicians who completed residency in 2007; and 3) a survey of approximately 1,000 residents who completed residency in 2006-2007. The aims of the interviews and surveys with residents were to explore their decisions to (or not to) train in abortion care and provide abortions, and to better understand the types of residency training opportunities available and the policies that govern them. Our results reveal significant gaps in the routine curricular integration of abortion care in general and medication abortion methods in particular. Our website review found that only 17.5% of programs offer information on abortion training

opportunities. We recommend enhancing this information as a way to contribute to the normalization of abortion, and to demonstrate compliance with the Accreditation Council for Graduate Medical Education requirement to provide "access to experience" in induced abortion. See the article *Reproductive health and cyber (mis)representations: A content analysis of obstetrics and gynecology residency program websites* by Foster et al. 2008 for more information.

Highlighting the need for expanded access:
Exploring self-induced abortion outside of the clinic setting

Recent legal cases, news stories, and clinical case reports have highlighted women's attempts to self-induce their own abortions with misoprostol and other methods, raising concerns about access to safe and legal abortion services in the US. In collaboration with Gynuity Health Projects, we conducted a mixed-methods study to better understand abortion self-induction in four US cities: Boston, MA; New York, NY; San Francisco, CA; and a city in Texas adjacent to the US-Mexico border. We conducted surveys with 1,425 women in primary and reproductive health care clinics serving a predominantly low-income population and in-depth interviews with 30 women reporting past experience with self-induction. Women reported using a range of methods; most were ineffective and a few were unsafe. Knowing someone who had self-induced was associated with the following factors: living in New York or Boston, reporting a barrier to reproductive health services, being between 25 and 34 years old, receiving government assistance, reporting Latina ethnicity, and having a history of two or more prior abortions. Motivations for attempting to end their pregnancies on their own included desire to avoid a clinic abortion, barriers to accessing a clinic abortion, and a preference for self-induction. Other studies have shown that women believe medication abortion to be less invasive, more private, more natural, and less of a "real" abortion; increased access to medication abortion may benefit women who value self-induction for these reasons. Additionally, we recommend removing restrictions on access to abortion care, such as parental involvement laws and funding limits, as many women in our study, particularly young women, described the cost of abortion as a barrier and chose self-induction to avoid telling their parents that they needed an abortion. One way in which the results of this research are being disseminated is through the Misoprostol Alone Working Group, an inter-disciplinary group dedicated to this topic and convened by Ibis, the Abortion Access Project, Gynuity Health Projects, and the National Latina Institute for Reproductive Health. See the article *Abortion self-induction in the US* by Grossman et al. 2010 for more information.

South Africa

Supporting public-sector provision of services:
Second-trimester abortion

Despite a progressive abortion law in South Africa, women still face significant barriers in accessing abortion care, including provider opposition, stigma associated with abortion, and a lack of providers trained to perform abortions and facilities certified to provide abortions, particularly in rural areas. These barriers can result in delays in accessing services and an increase in second-trimester abortions. While every effort must be made to reduce the need for later abortion in South Africa as morbidity and mortality risks increase with gestational age, it is also critical that access to high-quality second-trimester services be improved. With the Women's Health Research Unit of the University of Cape Town, we are conducting a study investigating second-trimester abortion in South Africa's public sector. We have collected data about the procedures used for second-trimester abortion, one of which is medication abortion with misoprostol, in several public hospitals, as well as data on women's and providers' knowledge and attitudes regarding second-trimester abortion, and are working with the clinical and administrative staff of these facilities to improve services. Preliminary results from the prospective study with 220 women undergoing dilation and evacuation surgical abortion (D&E) and 84 women undergoing medication abortion with misoprostol reveal that that D&E was significantly more effective than misoprostol (99.5% vs. 50.0%), though D&E clients had significantly lower gestational ages than misoprostol clients (16.0 weeks vs. 18.1 weeks). Complications were common with both methods (42.9% vs. 52.4%). D&E required significantly less time than misoprostol (median 10 minutes vs. 18 hours). Significantly more D&E clients compared to misoprostol clients reported high or extreme physical pain (75.7% vs. 59.5%) and high or extreme emotional discomfort (49.5% vs. 33.8%). Overall, clients undergoing both D&E and misoprostol procedures were somewhat or very satisfied with their experience (94.9% vs. 95.9%) and significantly more D&E clients compared to misoprostol clients were somewhat or very satisfied with the emotional support they received during the procedure (91.7% vs. 78.4%). This is the first comparative study of second-trimester abortion techniques in a developing country setting. As demonstrated in the US, D&E is more effective, requires a shorter hospital stay, and may have fewer severe complications. Second-trimester abortion services could be improved in South Africa by expanding D&E training, altering the cervical priming protocol, improving pain management, and introducing mifepristone. We plan to use these findings to inform a future randomized controlled trial comparing medication to surgical abortion in the second trimester.

Supporting public-sector provision of services:
Medication abortion

Mifepristone was approved for use in South Africa in 2001 and is currently available in the private sector, but not at free government health services. We are working with a coalition of local non-governmental and university-based colleagues in South Africa to support introduction of mifepristone and misoprostol medication abortion into public sector abortion services. Our research in collaboration with coalition partners has demonstrated that many women in South Africa would be early enough in pregnancy (8 weeks) to be eligible for medication abortion, and that integration of medication abortion in public surgical termination services is feasible. In partnership with Ipas and the University of KwaZulu-Natal, we

are conducting a study to evaluate the introduction of medication abortion services in public sector facilities in KwaZulu-Natal Province, South Africa, and assessing the impact on abortion-seeking behavior and provision. We hypothesize that the availability of medication abortion might encourage women to attend services sooner, and increase the capacity of existing facilities to serve more women. We hope that this new study will generate additional data that will support roll-out of medication abortion by the National Department of Health and will inform implementation of new guidelines for publicly funded, free medication abortion services. See the articles *Medical abortion: The possibilities for introduction in the public sector in South Africa* by Cooper et al. 2005, *Medication abortion in the private sector in South Africa* by Blanchard et al. 2006, and *Integrating medical abortion into safe abortion services: Experience from three pilot sites in South Africa* by Kawonga et al. 2008 for more information.

Latin America

Highlighting the need for provider education:
Abortion knowledge, attitudes, and practices among Peruvian physicians

Abortion is legal in Peru when a pregnancy endangers a woman's life or health, yet few women are able to access legal abortions for these indications. Among other barriers, physicians' lack of knowledge of the law and unwillingness to provide abortions for these indications contribute to women's inability to access legal abortion care in Peru. With colleagues at the Centro de Promoción y Defensa de los Derechos Sexuales y Reproductivos (PROMSEX), the Sociedad Peruana de Obstetricia y Ginecología, and the University of California, San Francisco, we surveyed physicians attending a workshop on the medical, legal, and ethical aspects of legal abortion about their knowledge of abortion techniques and abortion's legal status in Peru, their opinions regarding abortion law, their experience with induced abortion, and possible ways to improve their training in abortion provision. Our findings revealed that physicians were largely willing to provide legal abortions, but needed more knowledge, skills, and support to be able to do so. We are currently working with partners in Peru to address some of these issues by putting into place institutional protocols for providing legal abortions. See the article *Legal abortion in Peru: Knowledge, attitudes and practices among a group of physician leaders* by Pace et al. 2006 for more information.

Highlighting the need for provider education:
Physicians' knowledge and opinions about medication abortion

In most of Latin America and the Caribbean, abortion is highly legally restricted, but research has shown that women frequently use misoprostol to self-induce their abortions. With colleagues from the Population Council, we conducted a study in 2001-2002 with physicians from Honduras, Nicaragua, Mexico, and Puerto Rico to explore their knowledge and attitudes regarding medication abortion. Our findings were that medication abortion methods, particularly misoprostol, were used in these countries, but that knowledge of regimens and access to quality information about the methods were poor. Conflicting opinions regarding safety, efficacy, cost, acceptability, and potential for self-medication emerged, with some physicians voicing concerns about self-medication without proper counseling and others focusing on the potential for medication abortion to help reduce unsafe abortion risks in their countries. These findings are important as efforts continue to expand access to safe abortion services in Latin America. See the article *Physicians' knowledge and opinions about medication abortion in four Latin American and Caribbean region countries* by Espinoza et al. 2004 for more information.

In Latin America, some women obtain misoprostal in pharmacies, like this one in Mexico City, to induce their own abortions.

Highlighting the need for provider education:
Pharmacists' knowledge and provision of medical abortifacients

Though abortion is legally restricted in most of Latin America and the Caribbean, research suggests that many women obtain misoprostol from pharmacies without a prescription and self-induce their abortions. We conducted a study in a large Latin American city to learn more about pharmacists' knowledge and provision of medical abortifacients, including misoprostol. Through interviews with staff at pharmacies and mystery client visits, we learned that while abortifacient provision was common, knowledge about appropriate use of abortifacients was low and few pharmacy staff recommended an effective misoprostol dosing regimen to their clients. Improving training for pharmacy staff is important, particularly in legally restricted, developing country settings like this one where many women access treatment advice from pharmacy staff. See the article *Pharmacy provision of medical abortifacients in a Latin American city* by Lara et al. 2006 for more information. In addition to this research, we worked with colleagues in Latin America at the Federación Latinoamericana de Sociedades de Obstetricia y Ginecología and PROMSEX to collect information about misoprostol availability in different Latin American countries. See the article *Availability and obstetric use of misoprostol in Latin American countries* by Távara-Orozco et al. 2008 for more information.

Brief

Ibis Reproductive Health

Middle East and North Africa

Highlighting the need for provider education:

Pharmacists' knowledge and provision of misoprostol in Palestine

The creation of the wall in the West Bank, restrictions on freedom of movement, and enforcement of the Jerusalem identity card and permit system have severely disrupted Palestinian women's access to health facilities and contributed to increased rates of unintended pregnancy. As pharmacists play an important role in health service delivery in this region, Ibis conducted a study to examine the availability of misoprostol for early pregnancy termination at pharmacies. We conducted interviews with at least one pharmacist at 87 retail pharmacies in eight West Bank cities, which represented approximately 15% of all retail pharmacies in the West Bank. Our interviews included questions on misoprostol knowledge, availability, and provision patterns. We asked pharmacists about community and clinician awareness of misoprostol and the need for misoprostol among specific groups. Pharmacists expressed concern about the high rate of contraceptive failure and unintended pregnancy among women. Over three-quarters of the West Bank pharmacists in our study reported that women have come to the pharmacy seeking misoprostol for pregnancy termination and nearly 70% of these pharmacists reported that there has been a considerable increase in requests for misoprostol since the year 2000. Pharmacists reported varied knowledge about the misoprostol regimen for early pregnancy termination. Access to abortion and reproductive health services cannot be separated from the broader context of occupation. However, our study points to several avenues for expanding access to safe abortion services, including misoprostol-only education campaigns targeting pharmacists and clinicians.

Ibis interviewed pharmacists in the eight West Bank cities indicated above to examine the availability of misoprostol for early pregnancy termination.

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Other briefs in the series:

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Brief 3: Education and training

Ibis Reproductive Health

Ibis Reproductive Health aims to improve women's reproductive autonomy, choices, and health worldwide.

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