

# Introduction of medical abortion

Influence of existing policies  
programmes and services on  
access to MA

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# Global political and religious context

## From the independency: Evolution of the law

Liberalization of the traditionnal islamic law(sharia)  
*concerning the family*

- abolition of poligamy
- Minimum age of marriage
- Rights to the women: divorce, work, vote
- Legalize abortion
- Organize a national program for family planning

# Legal Framework

Law N°65 – 24 of July 1<sup>st</sup> 1965 :

- Authorizing “social abortion” until 3 months of pregnancy
- After the 5th child
- In a hospital or a sanitary establishment or in an authorized clinic;
- By a doctor legally exercising his profession.

September 26<sup>th</sup> 1973

- until 3 months
- In a hospital or a sanitary establishment or in an authorized clinic;
- By a doctor legally exercising his profession.

# he Project of the family planning program

## Availability of services

Access to services

Wide range of methods

Free choice

Free services

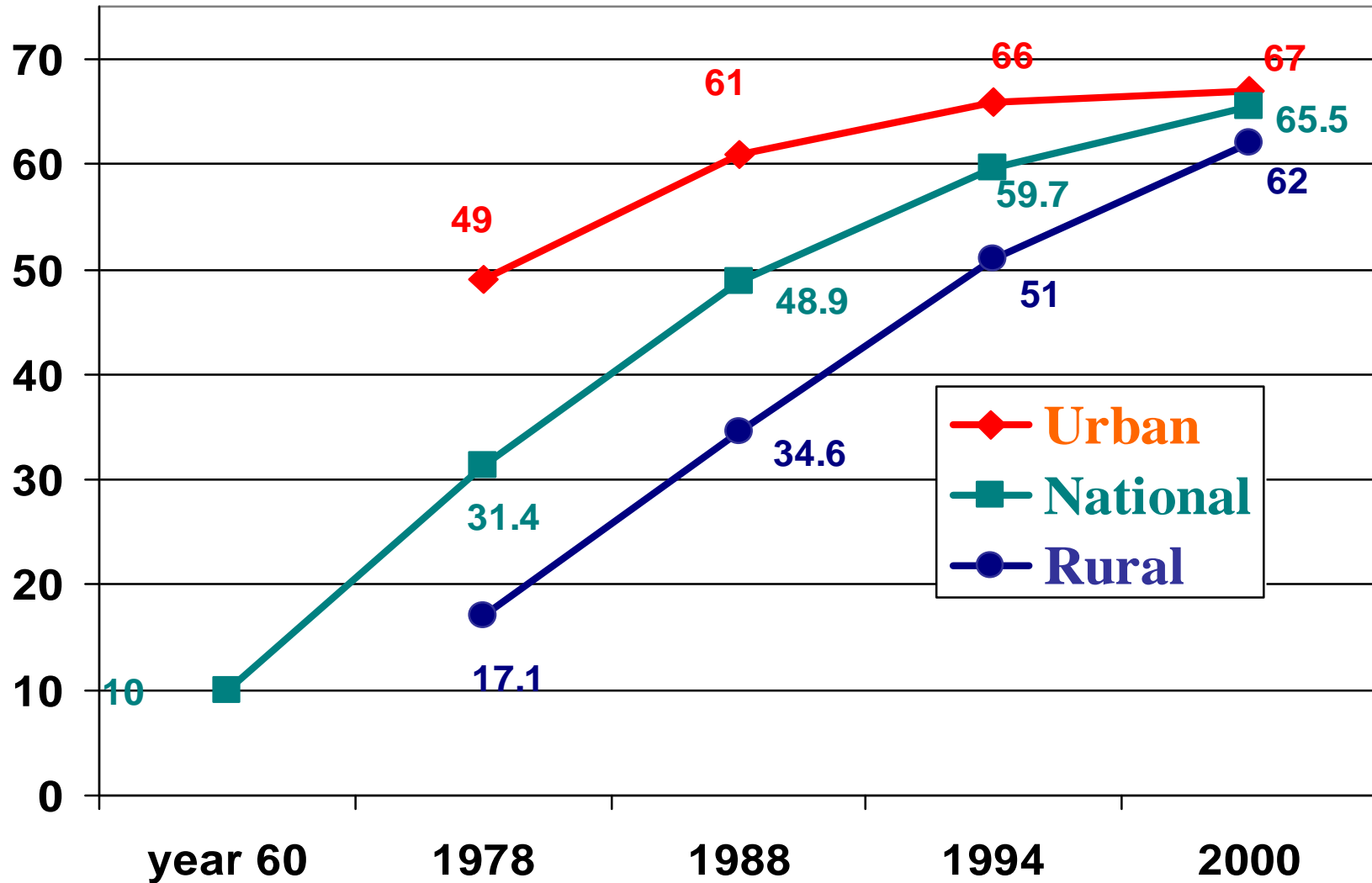
## Availability of methods

Contraceptive methods

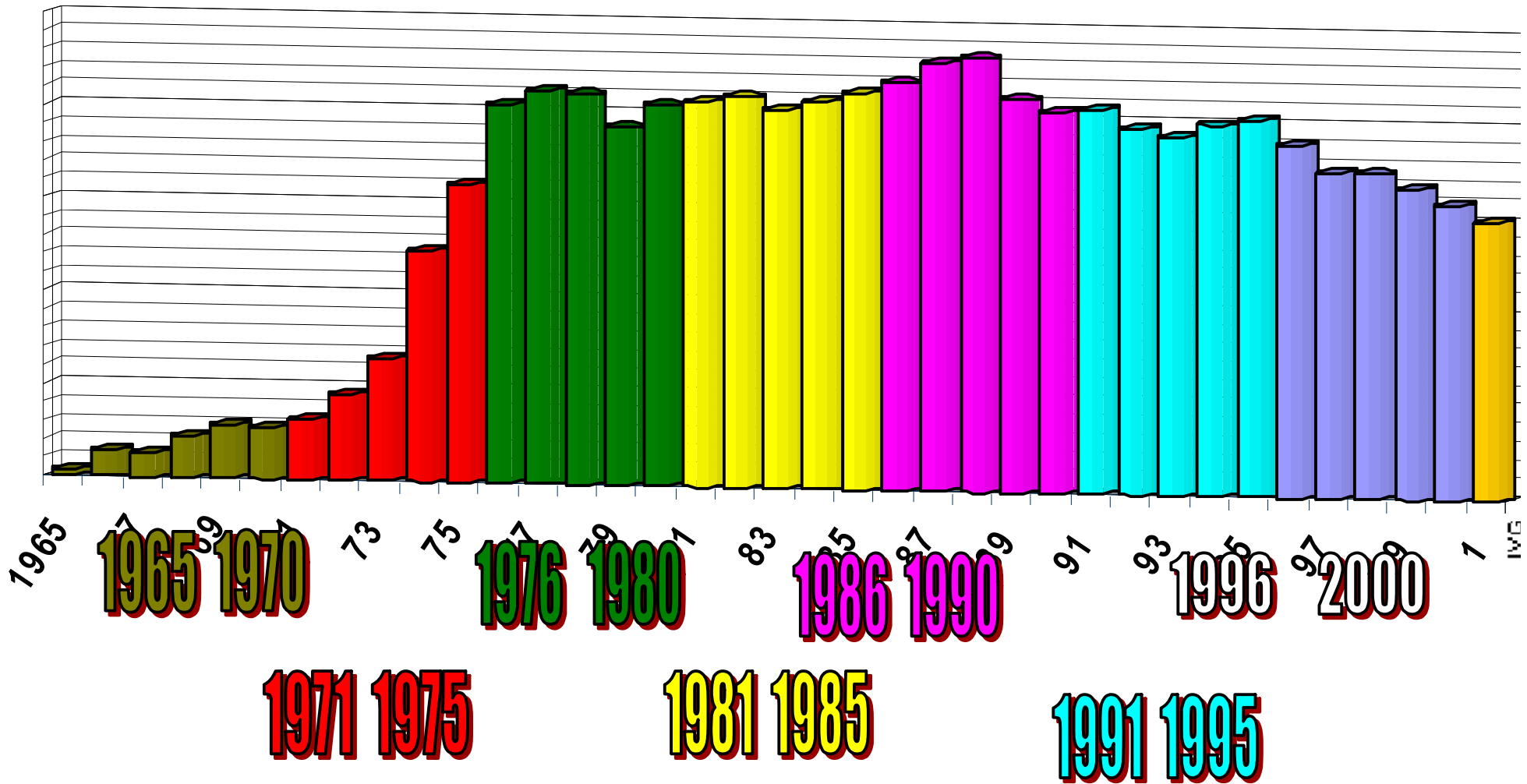
Abortion

# Contraceptive prevalence (%)

## Studies(1978-2000)



# Voluntary interrupted pregnancy 1965 - 2000



# considerations for the introduction of medical abortion :original aspects

***The choice*** of MA is related to the need of the women (or of the provider ?) to avoid the surgical procedure

***Consequences of failure*** : In Surgical abortion failure is a complication, but in MA women still have the « second chance » of surgical solution

***Efficacy*** on MA is related to accessible conditions : the age of pregnancy and the regimen adopted

MA give to women the opportunity to be free to “control her abortion”

# Medical Abortion

## Studies :

**Preliminary WHO multicentric study : i  
1994**

**3 Introductory trials ( Population Council  
/genuity) in 1998, 1999, 2001**

**875 women concerned**

**5 Structures concerned :**

- 3 O.N.F.P.clinics
- 2 C.H.U.



# Objective of Introductory studies :

(200 mg mifegyne+400µg misoprostol) which is different from the French regimen (registered in Tunisia)

Evaluate *Acceptability and Satisfaction* of the Tunisian women candidates to this method.

Evaluate the proportion of women who will choose the *Home use of Misoprostol* , safety and acceptability of the home use

Evaluate the acceptability and compliance to the protocol

Explore the ability of local staff to expand access to the method to new clinical settings

# RESULTS OF THE STUDIES

## EFFICACY AND COMPLIANCE

	1st study (191)	2nd study (214)	3rd study (341)
<b>Succes rate</b>	<b>91.1</b>	<b>94.4</b>	<b>95.6</b>
<b>Method failure</b>			
<b>Ongoing pregnancy</b>	<b>1. 6</b>	<b>1. 9</b>	<b>1. 8</b>
<b>Incomplete abortion</b>	<b>3. 1</b>	<b>1. 4</b>	<b>0. 9</b>
<b>Med. indicated surg. Interv.</b>	<b>1. 1</b>	<b>0. 5</b>	<b>0. 3</b>
<b>User failure (provider or women)</b>	<b>3. 2</b>	<b>1. 4</b>	<b>0. 9</b>

# **in introductory trials**

**local supervision**

**Study providers+  
n clinics providers**

**Intensive training  
Paris/PopCouncil**

## **TRAINERS**

**doctors-midwives**

**Local training in each proper clinic**

**Start of recruitment (pilot phase)**

**preliminary evaluation by the reference center**

**local training by providers (doctors) for all staff of clinics**

**one year evaluation of the clinics**

**Providers in clinical trials (ObGyn, Generalists, midwives)**



**ADVOCATES**



**PROVIDERS-TRAINERS**

**DOCTORS**

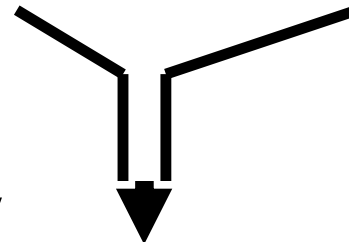
**Medical and scientific  
Background  
of training**

**TRAINING**



**MID WIFES**

**social aspects &  
counselling**



**delivery  
programms**

**TRAINING SESSION**

**Developing Bookets,  
brochures and service**

**Future providers**

# TRAINING PROCESS

## 3 Steps

1. Preliminary training by *experts*
2. Consolidation of training by *local leaders*
3. Local area trainings in each clinic: *the well trained -trainers*

# ***Extension Phase :Nov 2002-Dec. 2003***

*Ten Clinics (CREPF) in six cities*

**11341 Abortions**

**performed during this period**

**3681 MA with the association of mifepristone  
200mg-misoprostol 400µg**

**– 30.8% -**

**Succes rate : 95.6%**

# Progression of MA use

From 1997 to 2002 : 875 cases on research studies

From Nov 2002 to Dec 2003 : 2300 women

July 2004 : more than 4000 women (Data actually available on 3726 cases) About 50% of abortion is medical ( in the clinics involved)

## Providers

- midwives : 50%
- Doctors only: 50%

# Multifaced approach

## **Research**

Research studies by local researchers/PopCouncil  
Collaboration with local institutions:  
NFP / University departments

## **Dissemination**

Organisation of MA Symposia annually  
Publications in International scientific journals presentations in  
International scientific meetings

## **Background for legal approval**

Create local Support  
Encourage Local experts internationally recognized  
Obtain support of key policy makers and public health officials



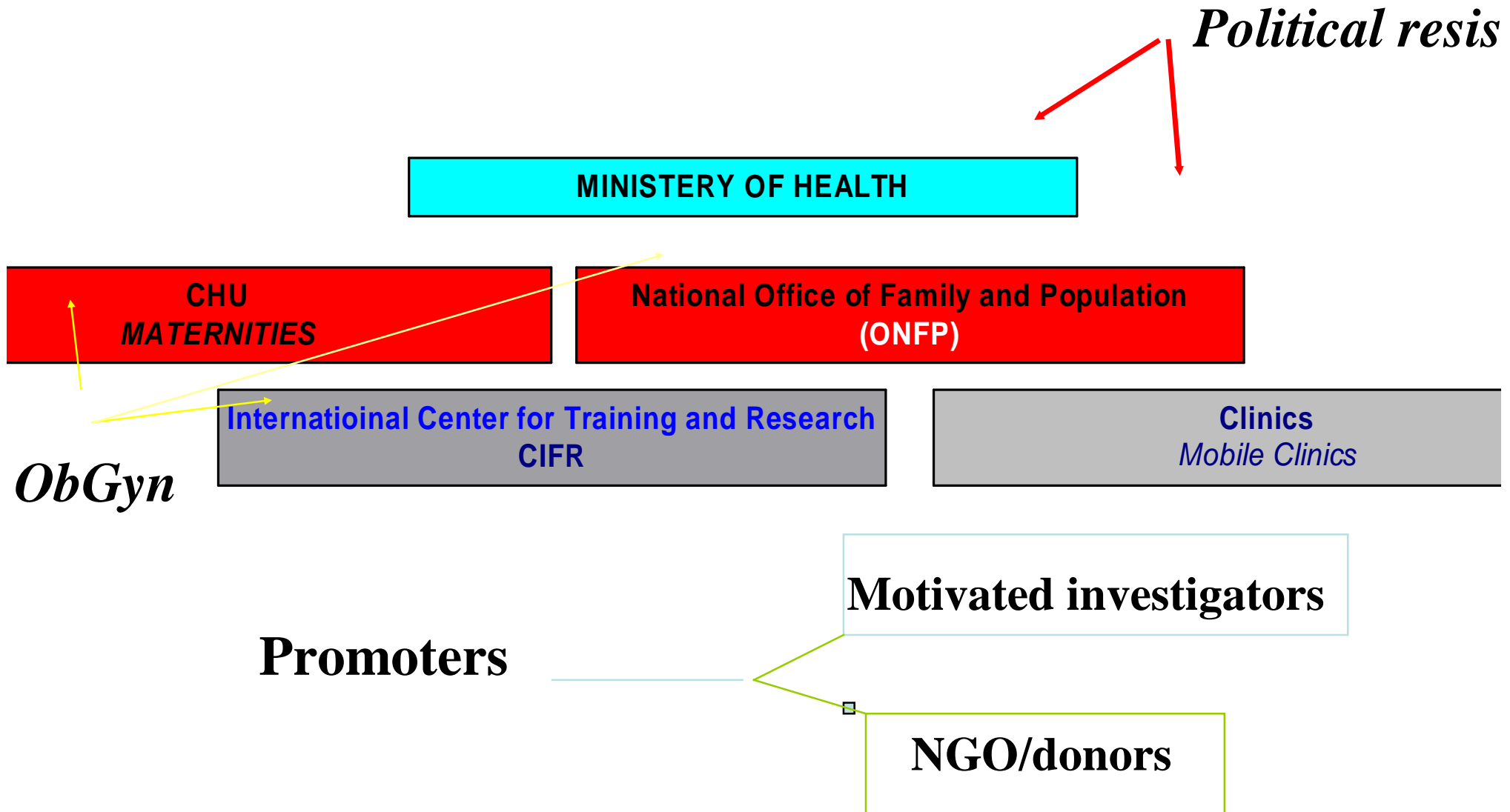
## MEDICAL ABORTION 2000 - 2004

1997

- \_ March 1997 : First study
- \_ November 2000 : Authorization (AMM) c Mifegyne in Tunisia
- \_ July 2002 : Training of 11 doctors & 1 midwife in Paris
- \_ September – October 2002 : Training of midwives and educational staff at the C International training centre following th development of a use protocol.
- \_ November 2002 : The starting of medica abortion in 10 O.N.F.P Centres.
- \_ Supervision and back up by 7 university structures
- \_ April 2003 :Evaluation on the three first months of use
- \_ September 2004: Evaluation of 18 mon of use . Preparing extension to private sector with training sessions.

2004

# INTIluence of contradictors



# Focal points of resistance/arguments

Use of Ultrasound for the diagnosis of pregnancy

- **Arguments: Easily available**

**Need to be realised by a specialist ( risk of error in datation, risk of undiagnosed extra uterine preganc**

- **Reality : loss of power of specialists/Generalists-Paramedical**

Home use of misoprostol :

**Argument: ILLEGACY**

**Reality: loss of power of medical-paramed. team/women (Limits of the Law – decriminalisation)**

# **and services on access to MA**

**The success of MA, as part of the Family planning programme, was tributary of:**

## **1) The political will**

Importance of the legal and institutional mechanisms  
mobilisation of resources (disponibility and access to information and services

- Access to MA in Public /Private sectors and interactive
- Strategies to improve these influences

## **2) The Socio-cultural environment**

- Status of women (education , work, Health....)
- procreative attitude of a population influenced by the social and religious briddles( opinion leaders)

# ***Lessons learned***

Motivation of key policy makers by local and international researchers

Develop local research of high scientific level

Disseminate scientific information

Develop communication between the different protagonists

Modify attitudes and barriers

# CONCLUSION

The keys for success of medical abortion

importance of support for a good  
acceptability

importance of training for a good efficacy and  
safety