Why medical abortion is important: issues of choice and acceptability

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Making pregnancy safe

- **Women often give birth at home.**
- **Women often miscarry at home.**
- **Women often induce abortion at home too.**

[After Toni Belfield, FPA UK, 27-09-04]

Choice = the right to decide whether or not to continue a pregnancy

- The right to decide the number and spacing of children, Nairobi 1985, Cairo 1994
- Voluntary motherhood (Mexico)
- Conscious motherhood (Poland)
- Every mother a willing mother, every child a wanted child (UK)
- Children by choice (Australia)
- Responsible parenthood (numerous)

The right to decide: prerequisites

- **Sexual relations that are consensual.**
- **Safe, available contraception.**
- **Safe, legal abortion**
  (whether or not contraception is used).

Many reasons for abortion

- **Risk to woman's health or life.**
- **Contraceptive failure.**
- **Social circumstances**

  e.g. poverty; rape; violent partner; young age, unmarried; in school; nearing menopause; family/partner opposed.
- **Population policy.**
- **Fetal indications: fetal abnormality, fetal sex.**

Respect for a woman's decision

- **Most women who have abortions are already mothers.**
- **Most of the rest are too young to become mothers, but will do so later in their lives.**
- **Others do not want children.**

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We must stop apologising for abortion and make it safe.

Why medical abortion is important

- **It offers a choice of method for both first and second trimester abortions.**
- **Choice of abortion method is important for both women and abortion providers.**
- **It encourages health systems to make abortion a primary care service.**

Why medical abortion is important

It can make abortion:

- **earlier**
- **more accessible**
- **safer**
- **less traumatic**
- **less medicalised**
- **less expensive –**

whether abortion is legal or clandestine.

Acceptability matters

- **When offered the choice, most women have an initial preference for a medical or a surgical abortion procedure.** **Norway, 69% of 226 women**
- **Most women are satisfied afterwards with the procedure they chose and most (though not all) would choose it again and recommend it to others.**
- **Acceptability of medical abortion with mifepristone + misoprostol has been high in all studies.**

Medical or surgical: aspects of choice for women

- **Safety.**
- **Efficacy – how often it works.**
- **Where provided, distance to clinic, number of clinic visits and procedures.**
- **How early it can be provided.**
- **How long it takes.**
- **How long and heavy the bleeding is.**
- **Avoidance of surgery.**
- **Avoidance of anaesthesia .**

Aspects of choice (2)

- Natural (happens in woman's body) vs. provider induced (done to the woman).
- Wanting to experience the abortion or not.
- Pain and other side effects.
- Dressed and sitting up vs. lying down and exposed, legs in stirrups.
- Privacy and confidentiality.
- How provider/health system treats women needing abortion.
- Feelings towards abortion.

Aspects of choice (3)

- **Cost**
- **Support of partner, family and friends.**
- **Household situation – e.g. indoor toilet, running water, menstrual pads.**
- **Children and other family members at home.**
- **Type of employment and time off.**

Study data

- **Strong preference for home administration of misoprostol (80+%).** **Vietnam, 1601 women**
- **Rural women reported fewer side effects at all sites.** **India, 900 women**
- **Medical abortion can be offered safely, effectively and acceptably in the outpatient family planning departments of urban and rural hospitals.** **India, 900 women**

Study data (2)

- **If a future abortion was required, 41.7% of those who had surgical abortions would opt for medical abortion; only 8.6% of those who had medical abortions would choose surgical abortion.**

  USA, 326 women

- **At one-week follow-up visit, 75% of adolescent girls found the procedure acceptable; that increased to 96% by the 4-week visit.**

  USA, 28 adolescents

Study data (3)

US Asian women were more than twice as likely as others to choose medical abortion because they believed it was safer. White women were twice as likely to select it because they considered it more natural. More educated women were more pleased about avoiding surgery. White and African-American women and women with more education felt significantly more comfortable taking one or both of the drugs at home than in the clinic. Nearly all groups found the method highly acceptable with few differences in overall satisfaction, willingness to choose it again or recommend it to others. USA

Acceptability: provider perspective

- **Medical abortion is a matter of giving information, dispensing pills, monitoring progress and giving support, with surgical skills required only for incomplete/failed procedures.**

  Surgical abortion is a simple procedure up to 14–16 weeks of pregnancy and a much more complicated procedure for later abortions. Both require surgical skills and equipment and aseptic conditions.

- **Main provider – obstetrician/gynaecologist, GP, nurse-midwife or family planning nurse?**

- **Who earns income from abortions?**

Acceptability: provider perspectives

In clandestine situations and where women self-induce abortion:

- **it is more difficult to prove that a medical practitioner gave the woman anything, and**
- **the complications with medical abortion are usually less terrible to take care of than with many surgical (invasive) methods.**

Conclusions

- **Important differences in characteristics of medical and surgical methods, and the context in which they are used and provided, affect choice and acceptability for both women and providers.**

- **Ideally, both medical and surgical methods should be available from both providers' and women's point of view, though each can be provided without the other.**

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