The Good News
Simplified medical abortion - increased access to safe abortion care

Development of safe and effective abortion care
- 70ies, Prostaglandin analogues discovered by Sune Bergström and his team at KI, Awarded the Nobel Price in 1982
- Induced uterine contractions and cervical opening
- Shown to act in synergy with progesterone receptor modulator
- Developed to Medical abortion
- Bygdeman & Swahn 1985

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- Increase access to safe abortion methods and stop outdated methods - Vacuum aspiration (MVA), medical abortion, misoprostol, "menstrual regulation", PAC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 counseling and contraception also for young/unmarried women
- Information on sexual and reproductive health and rights
- Empower women!

Disclosures of Financial Relationships
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Medical abortion is one of the safest medical procedures, with minimal morbidity and a negligible risk of death. Increased access to medical abortion can lead to a decline in maternal morbidity and mortality.
Impact of reducing barriers in access
Abortions 1983 - 2014

Medical abortion
- Highly effective, safe and acceptable method
- Can be used for all gestational lengths
- Can replace surgical abortion
- Mifepristone –
  Limited availability
  Approved in about 60 countries
  Expensive
Mifepristone alone highly effective
But priming with mifepristone increases efficacy, allows lower dose and less side effects

2012 Update of Updated WHO guidance on safe abortion
- Emphasizes the simplifying or streamlining of abortion care,
- Notes a high value on research to demedicalize abortion care
- Affirms that home use of misoprostol is a safe option for women

The Guidance suggests the evaluation of internet provision and telemedicine, as further alternative service delivery channels of safe abortion, as a subject for future research

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
Simplifying medical abortion  
Increasing Access to Safe Abortion Services

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
- Home use safe and well accepted also among, illiterate women with no transportation in rural areas in Rajasthan, India
  Inguar et al, Lancet Global Health 2015
- Extending outpatient medical abortion services through 70 days of gestational age
  Sachasza Smith P et al, Reid Health Matters 2015

2. Medical abortion at home using telemedicine
- www.womenonweb.org
- Telemedicine service
- Online consultation with a medical doctor
- Medical abortion conducted by internet/ email
- Helpdesk
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 to abortion.

I had an abortion

Provision of medical abortion using telemedicine in Brazil


- 570 women used telemedicine and self-administration of medical abortion.
- 367 women gave follow-up information about the outcome of the abortion.
- 257 (67.4%) women were pregnant up to 9 weeks.
- 73 (20.1%) were 10–11 weeks, and 29 (9.5%) >13 weeks.
- Significant difference in surgical intervention rates after the medical abortion:
  - 10.5% at 9 weeks, 15.5% at 11–12 weeks and 44.8% at 13 weeks.
- 42.2% of women who had a surgical intervention had no symptoms of a complication.

Results

- 1180 patients randomised (2011-2012);
- 597 (nurse-midwife) and 583 (MD).
- 12.4% did not return for FU (p<0.033).

Task shifting: Medical abortion provided by physicians or midwives

- RCT 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 regimen, theoretical and practical.

Kopp Kalner H, Gomperts R, Johansson M, Salomonsson E, Marinos L, K Gemzell-Danielsson

BJOG 2014 Jul 18.
Results, equivalence trial

- Equivalence for efficacy was established.
- There were no significant differences in safety parameters.
- 17 (1.8%) of patients had a vacuum aspiration.

Results - differences

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

Task shifting increases productivity and increases access to health care

Follow up: routine vs. self assessment

Objectives.
- To evaluate self-assessment using a low sensitivity hCG test (DUO-test, VedaLab, France)
  - at home and telephone FU
  - versus routine FU in the clinic.
- in medical abortion up to 63 days' gestation.

Additional questions:
- Is the test easy to use?
- Do women prefer one-stop treatment compared to hospital FU?

4. Follow up: routine vs. self assessment

Rationale
- Low rate of FU after medical abortion
- FU may lead to unnecessary interventions
- Only reason for FU is to detect a continuing viable pregnancy
- Failure rates (early MA) 1/1000
- s-hCG most effective, several limitations (acceptability, costs, logistics)
- s-hCG shows good correlation with u-hCG
- High sensitivity u-hCG positive in most women at 2-4 weeks FU

4. Home self test

Complete abortion

Incomplete abortion or failed test → Call the Clinic
Follow up: routine vs. self assessment

Assessment of the outcomes

Results

Home self-assessment

Women are able to safely have a medical abortion with home use of misoprostol 63 days of gestation and self assessment of the outcome of the treatment using a low sensitivity urine hCG-test. Self assessment is resource-saving. A step in demedicalising abortion and women prefer it. Women need to be counselled re the risk of an undiagnosed ongoing pregnancy. Any introduction of self-assessment will need a careful evaluation of the test as well as of user performance. Even women with low literacy can feasibly assess the outcome of an early medical abortion.

Medical abortion, "one stop clinic"

Karolinska University Hospital

Visit 1 on Day 1 to midwife (healthy women) or gynecologist:
- counselling, examination,
- contraceptive provision - Quickstart, and
- mifepristone 200 mg
- Cytotec 800 mcg, to take at home 24-48 h later, pain medication
- FU at 1-2 weeks, u-HCG (1000 IU) self test / Check Top, Exelgyn.

Women can chose between:
- surgical or medical abortion
- misoprostol at home or in the clinic
- FU in the clinic or self-assessment
Increasing Access to Safe Abortion and PAC Services
From bench - to - bed - to - the hands of women

Guidelines
Uganda MOH standards and guidelines on unsafe abortion; https://files.acrobat.com/a/preview/789cb0d3-9961-4d5-9-10a-6846cbb3c3
• WHO Guidance on safe abortion care 2012
• WHO Guidance on “task shifting” 2015
• WHO MEC 2015
Misoprostol in Obstetrics & Gynaecology;
• www.misoprostol.org
• www.figo.org
Task shifting increases productivity and increases access to health care

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