Volume 40 Number 3 September 2006 *ISSN 0019-0357*

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IPPF *Medical Bulletin*

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IMAP Statement on safe abortion

This Statement was updated by the International Medical Advisory Panel (IMAP) at its meeting in May 2006.

Introduction

An abortion is the termination of a pregnancy. It can be spontaneous (also called miscarriage) or induced. Induced abortion is a procedure commonly used throughout the world to terminate unwanted pregnancy. An abortion can be induced by surgical techniques such as aspiration or dilatation and curettage or medically by means of pharmacological agents. When performed in early pregnancy by well-trained practitioners in adequate facilities, induced abortion has an excellent safety record.

Abortion is characterised by the World Health Organization as unsafe when it is performed "by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both". Out of the 46 million abortion procedures performed each year, at least 40% occur in unsafe circumstances. These unsafe abortions carry a high risk of maternal mortality and morbidity, accounting for 68 000 deaths each year. In almost all countries abortion is legal under certain circumstances. Legality is not the prime determinant of safety: legal abortions are not always safe, nor are illegal abortions always unsafe. Restrictive abortion legislation does not substantially reduce the overall number of abortions but greatly increases the proportion performed unsafely. Provision of, or referral for, abortion – the right to choice – is an essential part of women's sexual and reproductive healthcare. As with all sexual and reproductive health services, the client's confidentiality and privacy must be maintained. To reduce unwanted pregnancies and the need for abortion, high priority should be given to expansion and improvement of contraceptive services.

Although early abortion, properly performed, carries little health risk, the dangers increase progressively beyond 10 weeks from the last menstrual period. Thus, efforts should be made to inform the public that abortion is safest when performed early, and women who contemplate abortion should be encouraged to attend as early in the pregnancy as possible. Services should then ensure that abortion can be performed promptly by skilled and well-trained personnel. A service that confines itself to early abortions must know where it can safely refer clients whose pregnancies are of longer duration.

Counselling and information

Every woman contemplating abortion should have access to supportive empathetic counselling, responsive to her personal circumstances and cultural background. Such counselling should include the full range of options and the opportunities for assistance. After a counselling session, some women require extra time to come to a decision.

In some circumstances, a woman may be under pressure from her partner, her family, or other members of society to have an abortion or to continue the pregnancy. Unmarried adolescents may be particularly vulnerable to such pressure. If coercion is suspected, this possibility should be discussed with the woman on her own. Women who may have been victims of sexual abuse should be referred for further support, as needed.

Whichever method of abortion is chosen, women should be fully informed about what to expect during and after the procedure, and how long it will take. The safety of the procedures and their foreseeable immediate and late side-effects and complications should be discussed and informed consent should be sought. When medical abortion is contemplated, the client should be informed about the drug regimens, how long the procedure will take, and the amount of bleeding and pain to be expected. Women who request surgical abortion should likewise be fully informed about what to expect, including the medication for pain management and the types of anaesthesia available.

The woman should be given contraceptive counselling both before an abortion and at any follow-up visits, and should have access to contraceptive commodities; but acceptance of contraception should not be a precondition for providing abortion.

A pregnant woman who is HIV-positive will sometimes feel under pressure to obtain an abortion. However, just as with any other client, she should be counselled and allowed to make her own informed decision. Nor should HIV positivity delay a woman's access to safe abortion services.

Pre-abortion care

The general health of the woman should be evaluated to detect any medical conditions that might increase the risk of an abortion procedure. When a serious medical condition exists, the abortion should be performed in a specialised facility where any risk can be reduced to the minimum and complications can be properly treated. Women should be screened for anaemia. Tests for ABO and Rh grouping should be provided where indicated, especially at higher-level referral centres, in case of complications or risk of complications that might require blood transfusion.

Pelvic examination must be performed to establish the duration of the pregnancy and to identify possible ectopic pregnancy, concurrent infection, or uterine abnormalities. The presence of a sexually transmitted infection (STI) increases the likelihood of post-abortion pelvic infection. Routine prophylactic antibiotics reduce post-abortion complications overall. Where infection is initially evident or identified by screening, antibiotics should be started before the abortion is performed.

Abortion techniques

The chosen method for inducing abortion will depend on the duration of the pregnancy, the training and skills of the provider, the facilities and medications available, and the preferences of the woman. In most cases the gestation can be determined from the date of the last menstrual period and the findings on pelvic examination. Ultrasonography may be useful when there is

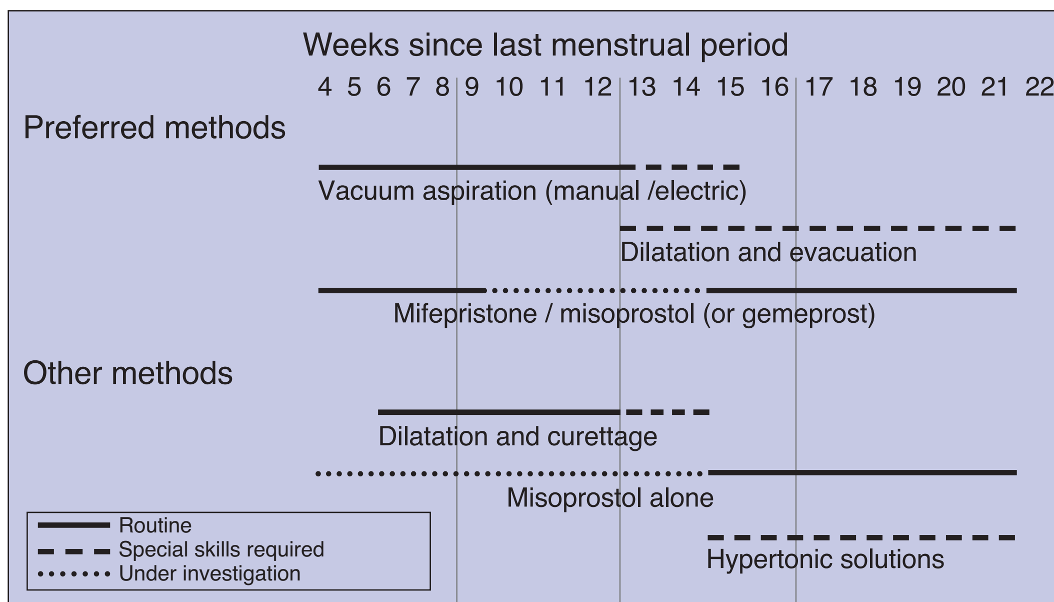

Figure 1. Methods of abortion by duration of pregnancy

clinical doubt about the duration of gestation or suspicion of ectopic pregnancy. Unless the woman has a serious pre-existing medical condition or the chosen method requires an inpatient stay, both surgical and medical abortion are outpatient procedures. Figure 1 illustrates the appropriate methods in relation to gestation.

Surgical methods

Vacuum aspiration

Vacuum aspiration is the preferred surgical method up to 12 weeks since last menstrual period, and some skilled practitioners can do it safely up to 15 weeks. The contents of the uterus are evacuated through a plastic cannula attached to a vacuum source. The vacuum can be generated either by an electric pump or with a hand-held plastic syringe. For aspiration beyond 10 weeks, if an electric pump is not available, use of a double-valve syringe is preferable to single-valve manual aspiration.

Surgical abortion requires local anaesthesia or light sedation, or both. General anaesthesia should be avoided except in some cases of late abortion, because it increases the risk. Unless the pregnancy is very early, aspiration will require either cervical dilatation by means of a mechanical or osmotic dilator (with or without a prostaglandin) or cervical priming with a prostaglandin such as misoprostol or gemeprost. The aspirated material can be examined to confirm the presence of products of conception.

Dilatation and curettage

Dilatation and curettage (D&C) is applicable for abortion up to 12 weeks, and highly skilled providers can do it up to 14 weeks. D&C should be used only where uterine aspiration or a medical method is not available, since sharp curettage carries higher risks and is more painful. Health service managers should make every effort to replace sharp curettage with vacuum aspiration.

Dilatation and evacuation

Dilatation and evacuation is the preferred surgical method for pregnancies of more than 12 weeks. However, it does require special skills and is usually done under sonographic guidance. It should be performed only in facilities where providers have a high enough caseload to maintain their expertise.

Medical methods

Pregnancy can be terminated medically by use of a combination of the antiprogestogen mifepristone and a prostaglandin, such as misoprostol or gemeprost. Up to 9 weeks this method is very effective and safe, with less than 5% of women needing a subsequent surgical intervention for incomplete abortion. Then follows a phase, from 9 to 12 weeks, when surgical abortion is preferable, because medical abortion with current dosage regimens is less effective, with greater blood loss and a higher likelihood that products of conception will be retained. Beyond 12 weeks, medical methods again offer a safe and effective alternative to surgical procedures. Services that offer medical abortion should have access to facilities for surgical intervention.

Both early and later medical abortions involve the administration of mifepristone followed, after a variable interval (up to 48 hours), by a prostaglandin. After 9 weeks, the prostaglandin administration often needs to be repeated.

An alternative to the antiprogestogen/prostaglandin combination is the prostaglandin misoprostol alone, although this seems less effective, slower to act, more painful, and more prone to gastrointestinal and other side-effects. Treatment regimens with misoprostol alone remain under investigation because of the wide availability and low cost of this agent. In view of concerns about teratogenicity, women who use misoprostol to induce abortion should be informed that, if it fails, abortion should be completed surgically.

The combination of methotrexate with a prostaglandin is not recommended since it is less effective than mifepristone/prostaglandin, the procedure is slow, and in case of failure there is a risk of fetal malformation.

Other methods

The intra-amniotic or extra-amniotic instillation of various solutions is less safe and less effective than dilatation and evacuation, and should be discouraged. Abdominal or vaginal hysterotomy is very seldom indicated for late abortion. Hysterectomy should be used only for women with a condition that would warrant the operation independently.

Post-abortion care

Post-abortion care, especially counselling and information on post-abortion contraception, should be offered promptly and is recommended after all abortions, whether medical or surgical.

Women should receive information on possible side-effects and complications and how to care for themselves after leaving the service delivery site. After surgical abortion, spotting and light bleeding may occur for several days or even weeks; nausea, with or without vomiting, may also be troublesome but generally

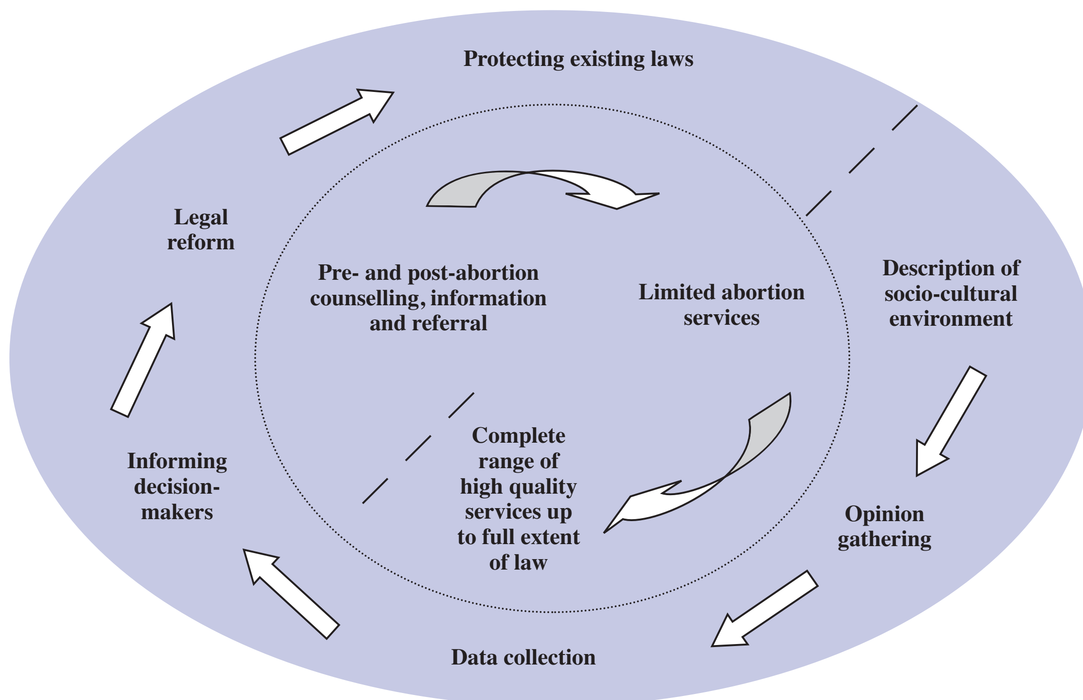

Figure 2. Continuums of care and advocacy for abortion services

subsides within 24 hours. After medical abortion the bleeding can be heavier, resembling menstruation. Cramping is common and can be treated with non-prescription pain relievers. Information on how to recognise complications and how to seek follow-up care should be provided.

After abortion, tests for continuing pregnancy are not generally needed and should not be performed routinely. However, if there is clinical suspicion of pregnancy, ultrasound or a pregnancy test may be indicated.

Counselling and contraception

The post-abortion period is an opportunity to address concerns, to explain symptoms, and to discuss future contraception. Women should be made aware that they can conceive as early as ten days after an abortion.

All methods of contraception can be considered for use after abortion, provided that the medical eligibility criteria are met. The diaphragm and cervical cap should not be used until 6 weeks after a second-trimester abortion, and intrauterine devices are more likely to be expelled if inserted just after a second-trimester abortion.

The time of an abortion is not usually an ideal moment for a woman to make a major decision such as whether to be sterilised. However, where a woman will have difficulty returning later for the procedure and makes the request, sterilisation by minilaparotomy or laparoscopy can be safely combined with the abortion. All women should be informed about emergency contraception and how it can be obtained. For some, advance provision of emergency contraception is desirable.

All women should be given information on the prevention of STIs including HIV. The importance of careful and consistent use of condoms should be emphasised, even if another method of contraception is being used.

Complications and late sequelae

Complications of abortion include haemorrhage, infection, and incomplete evacuation and in the case of surgical abortion cervical lacerations and uterine perforations. These complications, rare in early abortion, arise with greater frequency in late abortion. All service delivery sites should be equipped to recognise abortion complications, with staff trained either to deal with them or to refer appropriately for immediate care.

There is no evidence that having an uncomplicated abortion has any bearing on future fertility, causes adverse outcomes in subsequent pregnancies, or affects a woman's mental health. Evidence does not suggest an increased risk of breast cancer after induced abortion.

What Member Associations can do

IMAP supports the inclusion of abortion as a core strategy of IPPF's Strategic Plan. An important task for IPPF Member Associations is to increase awareness of and access to safe abortion services within their countries. Those with clinical remits should provide comprehensive safe abortion services to the full extent of the local law.

Figure 2 illustrates continuums of care for abortion services and advocacy efforts. The activities in the inner (clinical) and outer (advocacy) circles should be carried forward together. The clinical aspects have already been discussed. Advocacy strategies for safe abortion should begin with an examination of the law in relation to actual practice and to women's cultural rights. This would include issues of access to safe abortion services, regulations concerning who can undertake abortion and where, and parental or spousal consent. Next, opinions should be gathered from politicians, religious leaders, educators, leaders of professional organisations, the general public, women denied abortion, and women who have had abortions. The third stage is to establish systems that allow monitoring of abortion incidence, complications, and related mortality. This would include data collection on problems associated with unsafe abortion and on abortion-related complications. If decision-makers understand the public-health impact of unsafe abortion, they are more likely to push for legal reform. Campaigners for safe abortion services must tailor their messages for various target audiences – parliamentarians, politicians, health ministry officials, community and religious leaders, and the general public. Finally, public information campaigns are needed to reach women who do not know their rights to abortion under existing law.

Hormonal methods of male fertility regulation

Kirsten M Vogelsong

The development of a male 'pill' and other equivalents of female hormonal contraception would provide welcome additions to the existing limited options of condom, vasectomy, and withdrawal. Now, after more than three decades of research, such methods are on the near horizon. All the proposed approaches – androgens alone, androgens plus progestogens, androgens plus gonadotropin-releasing-hormone (GnRH) receptor ligands – seek to inhibit sperm production by exploiting the intrinsic negative feedback loop that regulates production of pituitary gonadotropins and gonadal steroids.

Androgen alone

In 1990 a ten-centre World Health Organization (WHO) study[1] demonstrated that weekly injections of 200 mg testosterone enanthate (TE) greatly reduced sperm counts without adversely affecting libido or potency. Detailed follow-up indicated that azoospermia or severe oligozoospermia yielded sustained but reversible contraception, with pregnancy rates of 0/230 and 4/50 couple-years, respectively; with lesser degrees of suppression (sperm count exceeding 1 million/mL), fertility was higher.[2] The regimen was judged acceptable by users and their partners, but many of the men would have preferred less frequent injections. Thus a longer-acting preparation, testosterone undecanoate (TU), was tested in subsequent trials.

A WHO-supported multicentre trial in China evaluated the contraceptive efficacy of an initial dose of 1000 mg TU, followed by injection of 500 mg every four weeks. Of the 308 men who participated in the study, 290 became and remained azoospermic or severely oligozoospermic (defined in this trial as less than 3 million sperm/mL); none of these men's partners became pregnant in the 6-month efficacy phase of the study,[3] and an acceptability study indicated general support, among the men and their wives, for the concept of hormonal male contraception. Most participants reported no change in their overall wellbeing, though some commented on the pain and inconvenience of frequent injections.[4] This regimen is being tested in a phase III contraceptive efficacy trial in 1000 Chinese couples, and the results will help policy-makers and service providers decide whether the time has come to introduce such methods in China.

Androgen/progestogen combinations

Several studies have indicated that a combination of androgen and progestogen suppresses spermatogenesis more effectively than androgen alone.[5] The progestogen can act synergistically by inhibiting gonadotropin synthesis and release, and there is also some evidence of direct negative effects at the level of the testis. Addition of a progestogen allows a lower androgen dosage, thus reducing the potential ill-effects of exogenous testosterone on the cardiovascular system and the prostate.

Most trials of this approach have so far been small, with sperm counts, rather than fertility, as the primary outcome measure. From these we can conclude that the degree of spermatogenetic suppression depends on the choice of steroidal compound and the route of administration.[5] Several regimens have produced high success rates in terms of azoospermia and severe oligozoospermia, indicating the promise of this combined approach. In a trial of testosterone implants (four 200 mg implants every 4–6 months) together with depot medroxyprogesterone acetate 300 mg injected every 3 months, the proportion of men with sperm count not suppressed below 1 million/mL was under 4% and there were no pregnancies in the 35.5 couple-years of the study.[6]

The results of an ongoing European trial sponsored by the pharmaceutical companies Organon and Schering AG will reveal the potential of a combination of depot etonogestrel and injectable testosterone undecanoate to suppress spermatogenesis. In collaboration with the CONRAD program and the drug manufacturer (Schering AG), WHO plans to initiate a contraceptive efficacy trial of injectable testosterone undecanoate combined with injectable norethisterone enanthate.

Androgens plus GnRH receptor ligands

Gonadotropins can be suppressed either by continuous occupation of the pituitary GnRH receptors or by blockade of the normal stimulation of this receptor – i.e., by use of an agonist or an antagonist. GnRH agonists require several weeks to down-regulate the receptors whereas antagonists suppress luteinising hormone and follicle-stimulating hormone almost immediately. Either method requires administration of replacement androgens.

Synthetic GnRH peptides have given promising results, in terms of sperm suppression, in monkeys and in small-scale clinical trials. For this purpose the antagonists hold more promise than the agonists, though in present form they are costly and would require daily injection. Current research is directed to finding new protocols for drug administration and developing less expensive long-acting or oral preparations.[7]

Acceptability and behavioural factors

Would hormonal methods of these kinds be taken up by men? As with all contraceptive methods, there are method and user factors.[8] Surveys indicate that many men would be content to share responsibility for contraception with their partners if provided with acceptable methods;[9] moreover, the great majority of women said they would trust their partner to be conscientious in this respect.[10] So far, studies of male hormonal contraception have shown high acceptability, with few if any adverse effects in the short term.[4,11,12] Instruments are being developed to detect changes in mood or behaviour, if any, for use in future clinical trials.

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