

# IMAP Statement on medical abortion

More than half of all pregnancies globally are unplanned, and one in every four, or 56 million pregnancies per year, ends in abortion.

## Introduction

This statement was prepared by the International Medical Advisory Panel (IMAP) and approved in September 2018.

Access to contraception and safe comprehensive abortion care remains uneven around the world and complications due to unsafe abortion are still significant causes of maternal morbidity and mortality. More than half of all pregnancies globally are unplanned, and one in every four, or 56 million pregnancies per year, ends in abortion.<sup>1</sup> Of these, an estimated 25.2 million are unsafe abortions. The vast majority of these unsafe abortions – 97 per cent – occur in low- or middle-income countries, which are more likely to have restrictive abortion laws, high unmet need for contraception, shortages of trained healthcare providers and limited access to quality health care.<sup>2</sup>

Lack of access to safe abortion care is further exacerbated in many settings by stigma, a lack of knowledge on sexual and reproductive health and rights (SRHR),<sup>3</sup> and what the Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights calls “a persistent discrimination against women and girls, and an unwillingness to address issues related to sexuality openly and comprehensively.”<sup>4</sup> Particularly vulnerable groups within this context are adolescents; women with disabilities; sex workers; women who are subjected to forced marriage, domestic violence, abuse or rape, or female genital mutilation; and women subjected to human trafficking.

IPPF is well positioned to work with its Member Associations and partners to further increase access to safe abortion care and contraception and step up progress towards the Sustainable Development Goals. Medical abortion has the potential to increase access to safe abortion care and to increase women’s autonomy and decision-making with regards to their reproductive choices and rights. It is time to implement evidence-based abortion services that promote, protect and fulfil the sexual and reproductive rights of all individuals everywhere.

## The purpose of this statement

The statement is intended to support and guide IPPF Member Associations and other SRHR and women’s organizations, including those providing information and services, engaged in advocacy and/or partnering with government and other key stakeholders. It is designed to raise awareness on medical abortion and provide service providers and advocates with information and tools to strengthen the provision of medical abortion services.

It aims to support and complement the IPPF Vision 2020 medical abortion report *Her in charge: Medical abortion and women’s lives – A call for action*. It reflects on experiences and models of medical abortion, and international recommendations. It is intended to serve as a reference document on medical abortion.

## Intended audience

The statement is aimed at service providers, advocates, programme staff, managers and volunteers in IPPF Member Associations and the secretariat, and other SRHR and women’s organizations.

## Recent developments in abortion care

The increasing use of medical abortion has revolutionized ease of access to safe abortion services. Research has led to progressively less medicalized, low-cost, safe and effective medical abortion treatment methods. Safe abortion care has transitioned from tertiary and secondary health facilities to the primary care level and is increasingly administered by mid-level providers including nurses and midwives, or by women themselves in their homes.

Task shifting of safe abortion care to non-physician providers has proved cost-effective even in high-income contexts.<sup>5</sup> An increasing number of abortions are performed earlier, even as soon as a pregnancy test is positive, with lower risk of complications for the woman.<sup>6</sup> In recent years abortion has shifted from outdated and often unsafe methods, or resource intensive care, to simple, safe, cost-effective and affordable care, even in settings with restrictive access.<sup>7,8</sup>

Although barriers to access remain, countries such as Nepal, Ethiopia and South Africa have seen a steep decline in abortion-related deaths in the past 20 years. This improvement in maternal mortality has been linked not only to legalisation but also to an increasing proportion of medical abortions and the involvement of mid-level providers in abortion care.<sup>9,10,11,12</sup> In Sweden, approximately 93 per cent of all induced abortions are medical and often administered by midwives. Of these, 55 per cent are performed before seven weeks of gestation and 84 per cent before nine weeks.<sup>13</sup> Most of the abortions involve only one visit to an outpatient clinic followed by self-administration of misoprostol at home and self-assessment of abortion completion with the help of a low-sensitivity U-hCG test.<sup>14,15</sup>

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In settings where abortion is legally restricted, the harm reduction approach can be used for women\* with unwanted pregnancy, to reduce unsafe abortions. The approach includes pre-abortion and post-abortion care, whereby a woman with an unwanted pregnancy is counselled in the clinic and provided with information on misoprostol use, according to internationally recognized dose regimens. The woman is also counselled on contraception and supported to choose a method that is safe, effective and suitable for her situation. She then has the abortion at home and is advised to return for follow-up. Women generally access these services through word of mouth or recommendations from other women, or by referral from primary care providers.<sup>16</sup>

Several online (telemedicine) services with qualified medical staff exist and can inform and support women who need an abortion. These advances increase women's autonomy and provide safe and accessible alternatives to women living in countries with limited or no access to safe abortion services.<sup>17,18,19,20</sup>

## What is medical abortion?

Medical abortion is the termination of pregnancy primarily using medication. It can be used as an alternative to surgical abortion, which requires admission to a clinic and a provider with basic surgical training.

Medical abortion, with the combination of mifepristone and misoprostol, or with misoprostol alone, can be used to induce abortion at any gestational age and is an alternative to primary surgical abortion. Misoprostol alone is not as effective as the combined regimen to achieve complete abortion.<sup>21</sup>

The steroidal anti-progesterone mifepristone causes the cervix to soften and dilate, increases uterine contractility and increases sensitivity to prostaglandins. Misoprostol, a synthetic analogue of natural prostaglandin E1, causes uterine contractions, resulting in the detachment of the gestational sac from the uterine lining and expulsion of the pregnancy.

Its efficacy depends on the dose and route of administration.<sup>22</sup>

\* IPPF recognizes that abortion may be required not only by women but also adolescent girls and transgender or trans men of childbearing potential.

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## Who can use medical abortion?

Almost all women are eligible for medical abortion, with gestational-age-appropriate services, irrespective of age, parity and underlying health conditions. Previous caesarean section or multiple pregnancies are not contraindications to medical abortion. Contraindications to medical abortion should be reviewed before treatment but these are rare. They may include allergy to mifepristone or misoprostol, chronic adrenal failure or long-time treatment with oral corticosteroids, porphyria and ectopic pregnancy. Caution should be taken in women with coagulation disorders or those taking anti-coagulant drugs.

## Safety and effectiveness of medical abortion

The safety and effectiveness of mifepristone and misoprostol for abortion is supported by extensive research,<sup>23</sup> and both drugs are included on the WHO list of essential medicines, where misoprostol is also recommended for the treatment of incomplete abortion, post-partum haemorrhage and the induction of labour.<sup>24</sup>

*Medical abortion is effective for inducing abortion.* The efficacy of medical abortion is very high but decreases somewhat with increasing gestational age. Complete abortion (without the need for surgical removal of an incomplete placenta) occurs in 95 to 99 per cent of cases up to 12 gestational weeks and in 92 per cent of cases in the second trimester.<sup>25,26,27</sup> In case of an incomplete placenta this can easily be removed by vacuum aspiration. Continuing pregnancy occurs in 0.5 to 2.9 per cent of pregnancies in the first trimester.<sup>28</sup>

*Medical abortion is safe.* The risk for complications after medical abortion performed according to established guidelines, such as severe haemorrhage or hospitalization, is below one per cent.<sup>29,30</sup> Evidence shows that uncomplicated medical

abortion does not impair future fertility, and that induced abortion has no negative impact on mental health and does not increase the risk for breast cancer.<sup>31,32</sup> Women who experience high fever, abnormal discharge, severe pain or heavy bleeding at any point during the process should seek medical attention.

As with all medications, mifepristone and misoprostol have side effects. Side effects of misoprostol include nausea, diarrhoea, fever, skin rash, bad taste and numbness. Uterine hyperstimulation may occur in the late second trimester. Women should be informed of these side effects, but also informed that these are usually of short duration, depend partly on the dose and route of administration, with increased symptoms in oral, sublingual or buccal compared to vaginal administration, and do not seem to increase hospitalization.<sup>33</sup>

## Pre-abortion care

Where available, highly sensitive pregnancy tests should be used to confirm pregnancy. The gestational age of the pregnancy should be confirmed to determine the most appropriate method of abortion. This can be done by assessing the duration since last menstrual period (LMP) in combination with a bimanual pelvic exam. An ultrasound can complement the exam but is not routinely required, unless there is a discrepancy between uterine size on palpation and gestational age by LMP.<sup>34</sup> If an ectopic pregnancy is suspected, the woman should be monitored or referred to facilities with laboratory and surgical services. Rh prophylaxis is not needed for a medical abortion without surgical intervention before 12 gestational weeks.<sup>35</sup> An IUD should be removed prior to medical abortion if possible. Pain treatment should be offered with NSAIDs such as ibuprofen or diclofenac, and more potent pain medication if needed.

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## Medical abortion – the treatment

*Up to nine gestational weeks*, medical abortion is ideally performed by oral intake of 200mg of mifepristone followed 24 to 48 hours later by 800mcg of misoprostol by vaginal, sublingual or buccal administration. A shorter mifepristone to misoprostol interval lessens the effectiveness. In case of scant bleeding, another dose of 400mcg of misoprostol can be administered after three to four hours using any route of administration.

*Above nine weeks gestation*, the same regimen above for mifepristone is followed 36 to 48 hours later by 800mcg of misoprostol administered vaginally (or sublingually). This is followed by repeat doses of 400mcg of misoprostol administered vaginally or sublingually, every three hours up to four doses, until expulsion of the pregnancy occurs. If vaginal bleeding has started, vaginal administration should be avoided due to impaired uptake of misoprostol.<sup>36</sup>

The uterus becomes increasingly sensitive to prostaglandins with increasing gestational age,<sup>37</sup> which means that the dose of misoprostol should be reduced when abortion is induced for maternal or fetal disorders in the late second (>23 weeks gestation) and third trimester. After medical abortion in the second trimester, access to surgical evacuation of potential pregnancy remains is recommended.

Different dose regimens and routes of administration are safe and effective for medical abortion. See: [www.figo.org/news/misoprostol-dosage-chart-new-release-0015613](http://www.figo.org/news/misoprostol-dosage-chart-new-release-0015613), <https://www.ipas.org/clinical-updates/static/CURHE18.pdf>.

Ovulation can resume as soon as one week after the abortion. In case contraception is not initiated at the time of abortion, it is crucial that women are well informed about where and when to obtain their method of choice.

## Post-abortion care and contraception

Evaluation of the outcome of abortion may be done in the clinic by an assessment of pregnancy symptoms combined with a pelvic exam, an ultrasound scan (if available) or hCG levels.<sup>38</sup> A follow-up visit after an uncomplicated medical abortion is however not necessary. The assessment of abortion completion can be done by women themselves in both high- and low-resource settings using a low-sensitivity U-hCG test, if such a test can be provided to them.<sup>39,40</sup>

Ovulation can resume as soon as one week after the abortion. Contraceptive counselling should therefore be provided prior to the abortion to allow for immediate initiation. For medical abortion where the abortion is expected to occur at home, many forms of contraception, including combined hormonal or progestin-only pills, and progestin-only subdermal implants, may be started with the first pill of the medical abortion (mifepristone) without affecting the success of the abortion procedure.<sup>41,42,43,44</sup> Injectables and intrauterine contraception, if there is no evidence of infection, can be initiated as soon as the pregnancy is expelled in the first trimester.<sup>45,46</sup> In case contraception is not initiated at the time of abortion, it is crucial that women are well informed about where and when to obtain their method of choice.

## Availability and quality of medical abortion drugs

The original misoprostol brand Cytotec<sup>®</sup> is still not licensed for medical abortion but its off-label use is widely accepted to ensure the use of medication that is quality assured. There are currently many generic formulations of misoprostol, and both mifepristone and misoprostol are widely available for purchase online without proof of prescription. Misoprostol that is bought online from reliable sources may vary in its amount of active medication but has not been shown to contain dangerous or ineffective substances.<sup>47</sup> Decreased active content is partly related to damaged packaging, as misoprostol is vulnerable to degradation when not properly sealed.<sup>48</sup>

Safe abortion care should be provided as part of comprehensive and integrated delivery of sexual and reproductive health services. The IPPF Integrated Package of Essential Services includes provision of safe abortion care as an essential component of service delivery.

## Benefits of medical abortion

- Medical abortion is a safe, effective, highly accepted and affordable method of abortion. Contraindications to treatment are rare and side effects are usually self-limiting.
- Medical abortion can be safely and effectively self-administered at home up to 10 gestational weeks.<sup>49</sup> Having an abortion in the privacy of their own home increases women's autonomy in abortion care and reduces the stigma associated with induced abortions.
- Medical abortion is a less costly and less invasive method than surgical methods of abortion and does not require surgical training.
- The assessment of abortion completion following a medical abortion can be done by women themselves using a low-sensitivity U-hCG test.<sup>50,51</sup>

## Recommendations for Member Associations and other organizations

### FOR SERVICE PROVISION

Member Associations should aim to provide early access to safe abortion care, with medical or surgical methods, according to the woman's choice. Safe abortion care should be provided as part of comprehensive and integrated delivery of sexual and reproductive health (SRH) services. The IPPF Integrated Package of Essential Services (IPES) includes provision of safe abortion care as an essential component of service delivery.

Member Associations should include medical abortion in their services as a fundamental reproductive right. To support increased access to medical abortion, Member Associations should ensure that:

- SRH service providers routinely educate, counsel and support women who choose medical abortion, including for self-administration.
- Information on medical abortion is available for clients to read and understand, including instructions on home use.
- SRH service providers, including mid-level service providers, are trained and updated on the latest dosage guidelines for medical abortion and provide medical abortion to those women who need it.

- All health facilities are equipped to provide medical abortion as a method of choice for women.
- Misoprostol and mifepristone, where available, are stocked in all health facilities that provide safe abortion care as part of the essential drugs supplies. This should also include post-abortion contraception for immediate start.
- Task-sharing among a wide range of health professionals, including midwives, nurses and auxiliary nurses, is enabled for provision of abortion services. Women who opt to self-manage aspects of their medical abortion according to their needs and preferences are supported.

Member Associations may choose to provide information on self-acquisition and self-administration of misoprostol; how home medical abortion can be safely done, including recommended dose regimens, gestational age limits, contraindications, when to seek clinical attention and self-assessment of abortion completion; and uptake of post abortion contraception, thereby increasing women's autonomy and scope of choice. Member Associations can also direct women who are considering over-the-counter or online acquisition of misoprostol to reliable sources for acquisition and give them contact information for qualified telemedicine services that provide abortion medication and comprehensive clinical guidance, such as: [www.womenonweb.org](http://www.womenonweb.org), [www.womenhelp.org](http://www.womenhelp.org), [www.safe2choose.org](http://www.safe2choose.org).

Member Associations should provide a wide range of contraception, including long-acting reversible contraception (LARC), and work towards subsidizing these contraceptives for all women, training and updating health providers in insertion and removal techniques, and making contraceptive counselling an integral part of safe abortion care. Post-abortion care clients should also be referred for other SRH services, including sexual and gender-based violence (SGBV), sexually transmitted infections (STIs) and HIV services, in line with the IPES.

Member Associations should provide specific support to young people in the context of safe abortion care and make abortion content part of their education programmes and outreach to young people. A young person seeking an abortion may be a person in need of protection or at risk of harm, and providers should follow local child protection procedures and make an assessment of needs.

Special consideration should also be made when providing medical abortion to other vulnerable groups including women with disabilities; sex workers; women subject to forced marriage, domestic violence, abuse or rape; women subjected to female genital mutilation; transgender or trans men; and women subject to human trafficking. Based on IPES, there should be mechanisms in place for clinical, psychosocial and protection services for these groups.

#### **FOR POLICY AND ADVOCACY**

Member Associations can:

- Advocate with governments for the development and implementation of laws, policies and guidelines to significantly scale up access to safe abortion care for all women, especially those who are left behind by health systems.
  - Lobby governments to remove abortion from the penal code and end criminal penalties for women who use medical abortion on their own. Regulations and health systems guidelines should make clear that self-management is permitted.
  - Work with national and sub-national stakeholders, including governments and civil society organizations, to overcome structural, social and cultural barriers, including stigma, and lack of training of providers and denial of care.
  - Work with relevant advocacy groups towards reducing negative perceptions of abortion, making early access to abortion and post-abortion care, as well as contraceptive counselling, an essential part of women's health care services.
  - Advocate for task shifting of safe abortion care to mid-level providers, including nurses and midwives, and for use of telemedicine services for medical abortion.
- Create awareness within health systems and services that safe abortion care can be a platform for outreach to women that can increase reproductive rights and health on a general level.
  - Spread information on the safe use of misoprostol for abortion at recommended dose regimens.
  - Work towards registering medications for safe abortion and ensuring access to quality-controlled mifepristone and misoprostol at affordable costs in settings where misoprostol is not registered for abortion treatment.
  - Increase knowledge on access to quality-assured misoprostol by accessing country-specific availability and quality of abortion medications in the IPPF Medical Abortion Commodities database ([www.MedAb.org](http://www.MedAb.org)) – a free, searchable database of mifepristone, misoprostol and combipack availability by country.
  - Advocate for inclusion of mifepristone and misoprostol in lists of essential medications at the national level.
  - Advocate for comprehensive abortion services including medical abortion to be available in service delivery sites serving women in humanitarian settings, to address both the high unmet reproductive health needs of these women and the consequences of gender-based violence.

IPPF, as a global service provider and leading advocate of sexual and reproductive health care, pledges to uphold its commitment to providing gender-sensitive and rights-based comprehensive abortion care to all, and to working in partnership with others to ensure that the conditions and structures are in place to help women access safe abortion in the way that works best for their lives.

Member Associations can advocate with governments for the development and implementation of laws, policies and guidelines to significantly scale up access to safe abortion care for all women, especially those who are left behind by health systems.

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## WHO WE ARE

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.



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