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Reconceptualizing safe abortion and abortion services in the age of abortion pills: A discussion paper

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A B S T R A C T

At the conference "Developing an Advocacy Agenda for Abortion in the 21st Century and Making Change Happen" held on 5–7 September 2018, Lisbon, Portugal, organized by the International Campaign for Women's Right to Safe Abortion, it was argued that abortion services not only need to be treated as a bona fide form of health care but also completely reconceptualized, particularly because of the influence of medical abortion pills. It emerged, however, that there is no consensus on how this reconceptualization should be configured. Indeed, substantial differences arose, or so it appeared, complicated not only by different exigencies in national settings but also reflecting differing perspectives, specifically, those held primarily by health professionals compared to those held by advocates who felt they spoke for women needing abortions. In the course of these discussions, questions emerged on how much women should be able to do on their own, whether and why services were necessary in every case, where services should be located, what they should offer, who should provide them, and who should be in charge of the process.

The biggest discussion was over the extent to which women can safely self-manage use of medical abortion pills for abortion in both the first and second trimester, and to what extent health professional control should be relinquished. Regardless of these arguments, however, since 1988 with the discovery in Brazil that misoprostol is an abortifacient, over-the-counter access to medical abortion (MA) pills began to put self-management of abortion on the map. Today, self-management is happening in almost every country, and we have no idea how many abortions are taking place

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anymore. Moreover, because of the work of safe abortion information hotlines, there is a growing body of evidence that self-management of abortion by women is safe – or at least far less unsafe than what prevailed in the past.

Looking beyond the abortion rights movement, the crux of the issue is whether the state should continue to control abortion, with power over individual decisions delegated to the medical profession – or whether, as has been happening at a snail's pace for the last half century, and as with contraception and emergency contraception too – control can and should be more and more in women's hands.

This paper examines these perspectives and attempts to describe what a consensus might look like. It concludes that convincing governments and conservative health professionals to accept a large dose of self-management will not be easy.

Background

Several presentations at the Lisbon Forum, "Developing an Advocacy Agenda for Abortion in the 21st Century and Making Change Happen" in September 2018, addressed the issues raised by abortion with pills with regard to how abortion services should be provided in the future. The most important change in thinking is about what constitutes an abortion itself, because with MA pills, a health professional does not "perform" or "provide" an abortion, as with aspiration and surgical methods. The health professional may maintain control over prescribing and provision of the pills, in line with health service regulations and the law, but when a woman uses the pills – vaginally, buccally or sub-lingually – it is the pills that cause an abortion [1]. This has made women think differently about what it means to have an abortion and to demand that access to the pills requires a whole new type of provision. It is what Cristina Villarreal, former director of the clinic Orientame in Colombia, meant when she said that these are "the most awaited pills" [2]. She was referring to a new sense of being able to control not only the abortion decision but the process itself. You get the pills; you use them; you have an abortion.

This is far from simple, however, when one looks at whether, where, from whom, and how women are currently able to access MA pills in their countries and localities, or not. On the one hand, groups such as Women Help Women argue very forcefully that women in many countries are safely self-sourcing pills and self-managing their abortions outside of clinical contexts. Kinga Jelinska points out that self-managed abortion is as much a harm reduction strategy where abortion is legally restricted (far less unsafe than traditional unsafe abortion methods) as it is a form of exercising one's reproductive rights. Susan Yanow, also from Women Help Women, calls for putting the pills into pharmacies and from there directly into women's hands. Their evidence is based on the experience of safe abortion information hotlines and accompaniment collectives in at least 20 countries that are run by women who are not health professionals but who have educated themselves to a high degree with existing knowledge and experience, using first and foremost World Health Organization (WHO) and other clinical guidelines [3].

An example is a hotline in Indonesia called Samsara [4]. Their experience is that it is easy to find pills from pharmacies, the internet, or street sellers but without a trusted source, it is impossible to know whether the pills are bona fide and effective. Many are not. Indeed, they know of far fewer trustworthy sources than what they call "scammers". Their website in 2018 listed five sources of trustworthy pills and 14 untrustworthy ones [5]. Moreover, these change regularly; they have to keep up to date in order to be able to provide the information women need. The regulatory agencies of countries where almost all abortions are illegal do not take responsibility for this situation, though it could be argued that they ought to do so. But they would probably reply that they cannot regulate the sale of medications that are not and cannot be approved for the use that is made of them, when that use is outside the law.

One of the consequences of this is that the poorer the country and the more restrictive the abortion law, the more problematic the situation is, because there is less information available to women on effective brands and effective use (how many pills, how often, how to use), and less knowledge of whether the outcome is a complete abortion or not. This creates anxiety and fear; women are more anxious to seek help because they are not sure one way or the other. However, they may receive less than optimum health care when they do seek professional help because in many hospital emergency rooms, MA pills are not available and vacuum aspiration or even D&C may be used to deal with bleeding that may be perfectly normal – except the woman cannot say she had used pills because she may be reported to the police.

The contrast with informed self-use – simple, safe, highly effective, few or no serious complications and back-up care available if needed – is like night & day [6]. Recent research supports this perception. In Madagascar, for example, a qualitative study of 19 young women with an average age of 18–21 at abortion found that they sought advice from partners, friends, family members, and/or traditional practitioners and healthcare providers. Misoprostol was easily accessible via the formal and informal sectors, but the dosages and regimens the women used on the advice of others were extremely variable and often far from WHO guidelines. One woman, for example, took a total of 10 misoprostol pills, one per hour. Regimens like this were often ineffective, resulting in failed abortion, incomplete abortion, heavy bleeding/haemorrhage, strong pain, and infection [7].

Self-management without good pills or correct information and support should never be the alternative to an unsafe abortion from an unskilled and possibly unscrupulous provider. For some women, however, that is what self-management currently consists of. This makes some health professionals sceptical that self-management is the best or only answer.

On the other hand, women can be incredibly creative in overcoming the limitations they have to live with. In Chile, for example, use of abortion pills has been taking place illegally yet involving the healthcare system without it being said. A qualitative study among 30 university students who needed an abortion found that they went for an ultrasound scan both pre- and post-abortion, and when they had any concerns post-pill use, they went for post-abortion care. In between they studied how to use the pills and bought them from a network of women who had themselves previously needed the pills, which was known to many students. In some cases, they aborted overnight in their parents' or a relative's home without anyone else knowing. Even with help and support from their contacts, partners and friends, however, they said the clandestine situation created uncertainty and fear, which dominated the whole process: finding and purchasing the pills, addressing uncertainty about correct doses, not being sure it was going as it should, and not knowing whether the abortion was complete. There was a high perception that failure and complications might be occurring; hence, many sought post-abortion care “in case”. It seemed probable that when they went for a post-abortion check-up, even though they did not say they had induced an abortion, the clinical staff would have known, or guessed. That needed trust. The whole process required information, time, privacy, support, resources, and the ability to deal with risk [8].

Although there are only a few such studies to date in countries with restrictive abortion laws, they indicate a far from ideal situation. The students in the Chile study were in a comparatively highly supported situation; not everyone can expect to have the same access to help or bravery.

A few years ago, a British colleague wrote a paper that asked: how can a state control swallowing? [9] But the fact is, the state can and does in many countries today. In Brazil, for example, MA pills are a banned medication and can only be obtained for the most part on the black market. In Egypt too, unless you know someone in a hospital with access to the pharmacy, you will find it very difficult indeed to find pills. There is always the internet, but packages (including from feminist sellers) may take 2–4 weeks to arrive, and in some countries, such as Northern Ireland, the post is being checked for all sorts of drugs, and packages are confiscated regularly. Women do manage to find the pills, even in the most rural and resource poor settings. But we know little about what happens after that.

Many more studies like those from Chile and Madagascar are needed to understand the myriad experiences of women who are trying to find and using MA pills to induce an abortion outside the health system. But one thing is clear. In a place like Yemen, where it can take women more than 12 h to travel 250 km across a war-torn desert for a safe abortion [10], access to the pills locally and informed self-use would be life-saving.

Positive changes in broadly legal settings

The good news is that much research has been initiated by progressive and feminist-thinking health professionals on how to simplify the use of MA pills to women's benefit in both the first and second trimester, with the understanding that over-regulation and over-medicalization, often imposed out of lack of experience and caution in the early days, are not clinically necessary. The World Health Organization has supported much such research, and their guidelines have served as a reminder that it is not "just feminists" who support these changes but that well-documented, scientifically sound research does so too.

Here are descriptions of three kinds of processes involving only one interaction with a health care professional as the optimum way to ensure women can obtain and use medical abortion pills as early as possible with few or no built-in delays:

1. Pharmacy workers can provide correct and complete information on safe and effective use of MA pills with simple training. In a study in Nepal, 70% of 992 women were $\leq$6 weeks pregnant when they sought MA pills from a local pharmacy. Only 3% were $\geq$10 weeks pregnant. The rate of complete abortions was 96.9–98.8%; the women reported no serious complications, and satisfaction levels were high. In countries and rural areas where doctors providing abortions are few and far between, policies should be formulated to allow pharmacy workers to provide MA for first trimester use [11,12].

Indeed, in the context of rigorous research, WHO supports this role for pharmacy workers, who are often the first point of care to be approached in a community, especially when doctors and hospitals are scarce or expensive. WHO's 2015 guideline endorses independent provision of medical abortion in the first trimester by pharmacists to:

- Assess eligibility for medical abortion,
- Provide the medications and advise how to manage the process and common side-effects independently, and
- Assess completion of the procedure and the need for further clinic-based follow-up [13].

The second most recommended source of pill provision are midwives and nurses, who need minimal training as part of their medical education. Based in the community and in primary care settings, they are far more available than doctors. In Indonesia, for example, the number of midwives is four times more than the number of doctors and 26.5 times more than the number of obstetricians [4].

2. Telemedicine is an extremely popular form of provision of MA pills where it has been set up. It's a service delivery model crying out to be imitated. It's as relevant for high-resource as for low-resource settings. It's one of the most inexpensive ways to provide safe abortion care, and combines giving a role to health professionals with a high level of self-management by women. With telemedicine, a health professional is involved from a distance and the woman can obtain a prescription for the pills through a phone or online consultation. Telemedicine services were first initiated in Australia by the Tabbot Foundation in Tasmania, by Dr Paul Hyland, particularly for women living in rural areas who found it difficult to travel long distances to receive abortion services, a problem for women living in rural and remote places globally. Telemedicine was so popular with patients that his surgical abortion services became less and less used, and he had to close down his clinic because it was no longer financially viable. Meanwhile in only a few years, the Tabbot Foundation expanded its telemedicine services into seven Australian states and eight cities. Then, unexpectedly in March 2019, in spite of high satisfaction levels among service users and increasing demand for MA pills across the country, they had to close down because the costs even to run this service were impossible to cope with [14].

In the USA, in 2015, there were more than 700,000 searches on the internet by women looking into self-induced abortion as more and more clinics were closing because of anti-abortion led legal and

clinical restrictions [15]. Telemedicine was taken up in Iowa to try and reverse this situation. With the first telemedicine services, the woman has pre-abortion assessments carried out at a clinic that stocks the abortion medications but does not have a physician on site. Then, a remote physician reviews the results of the assessments, speaks with the patient by video conference, and authorizes the local clinic to dispense the medications. While this model increased the number of sites in Iowa offering abortion services, it still requires the patient to visit a clinic that has mifepristone in stock (unlike misoprostol, mifepristone cannot be distributed by US pharmacies). An alternative model that was tested used a direct-to-patient approach, in which the medications were provided directly to eligible patients by mail. The patient obtained screening results locally, and could then speak with the clinician from her home [16].

These US models were obviously more bureaucratic and costly than necessary, and probably made it less feasible to have a very early abortion. But they showed that it is regulations imposed from above that can prevent an obviously safe process from being kept simple and inexpensive. The "screening" involved was almost entirely due to the requirement of an ultrasound scan to date the pregnancy and check that it was not ectopic. In addition, the refusal of the US FDA to allow mifepristone to be obtained from a pharmacist alongside misoprostol was and is pure bureaucratic stubbornness and cannot be justified clinically. With no other medication of this kind does a doctor need to watch the person put the pill into her mouth and swallow it.

3. Uruguay, a small country with only one main maternity hospital, found a way to support medical abortion pill use to prevent deaths and complications from unsafe abortion well before actual abortion law reform took place in 2012 [17]. The hospital's obstetrics & gynaecology clinic invited any woman who was considering induced abortion to make an appointment to receive information. At the appointment, in the outpatient clinic, she was given directions on how to use medical abortion pills safely and effectively, where to buy them (a pharmacy), what dosage and regimen to use, and to come back to the hospital if anything went wrong or if she was afraid the abortion was incomplete. This had been cleared in advance with the Ministry of Health as a harm reduction strategy.

Today, Uruguay still has hospital-based, outpatient abortion care, and the same simple process is still used, except that the woman can get a prescription for the pills directly from the hospital. When abortion became legal in Uruguay in 2012, it became almost immediately universally available, because of the registration of MA pills and the absence of delay caused by having to train cadres of professionals in surgical methods. The only barriers are a five-day waiting period and conscientious objection by some doctors that mean other causes of delay.

> "*In Uruguay, we don't have doctors who do abortions. Abortion with pills is the only way… Health professionals are willing to be involved before and after, but not in the abortion.*" (Lilian Abracinskas, Executive Director, Mujer y Salud en Uruguay, Personal communication, 2017.

Nevertheless, despite these limitations, abortion provision had been simplified to providing information, prescribing pills, and offering a follow-up appointment – if the woman has concerns. It is that simple.

4. Use of technology to make the process even more self-managed

In South Africa, a team of researchers tested the use of a mobile phone calculator for determining gestational age. The woman enters the first day of her last menstrual period onto a website, which does the calculation. When compared to ultrasound measurement, among 78 women, on average the women overestimated gestational age by only 0.5 days and first sought an abortion 10 days after pregnancy confirmation. Researchers concluded that the calculator was accurate and helpful and could potentially lead to earlier abortions [18]. It would also make ultrasound less necessary (thinking of those insistent doctors who just cannot let ultrasound go).

Secondly, there has been research to find a pregnancy test that women can use at home after using the pills, to ascertain they are no longer pregnant, thereby eliminating the need for a follow-up visit to the clinic in almost all cases. Several studies have investigated different pregnancy tests. One, in Vietnam in 2016, compared the accuracy, feasibility and acceptability of two urine pregnancy tests (used by 300 women each) in assessing abortion outcomes at 3, 7 and 14 days after mifepristone administration. The multilevel urine pregnancy test (MLPT) was more reliable than the high sensitivity urine pregnancy test (HSPT). The researchers concluded that with the MLPT, women can know the outcome as early as three days after taking mifepristone. Most women found the tests easy to use and said they would prefer future home follow-up with a pregnancy test [19].

5. Removal of unnecessary clinical procedures to increase access and reduce barriers and costs

Canada has rapidly taken a path worth emulating in this regard. Although it took them an unconscionable amount of time to allow medical abortion pills at all (today they now have their own brand), once they decided to go ahead, they moved with the speed of light to bring abortion pills into the 21st century. In January 2017, mifepristone for medical abortion was made available for the first time, but initial restrictions on prescribing and dispensing created geographic access barriers. Partnering between the University of British Columbia and decision makers led to removal of federal requirements for watching the woman take the mifepristone pill, practitioner training, practitioner registration, and importantly, physician-only prescribing and dispensing of pills. Pharmacist dispensing and nurse-practitioner prescribing are now allowed in Canada.

Then, as of 16 April 2019, Canada removed the last federal restriction on mifepristone. Practitioners are not required to order an ultrasound scan before prescribing mifepristone for medical abortion prior to 63 days of pregnancy [20]. Hopefully, these women-friendly guidelines will serve as a model to emulate and raise the bar elsewhere – because this is precisely how involving health professionals and allowing a high degree of self-management by the woman can work.

The National Abortion Federation Clinical Policies Committee has just published a recommendation on foregoing Rh testing and anti-D immunoglobulin for women presenting for early abortion [21]. The paper provides a succinct summary of the wide-ranging differences in policy on this issue and the limited evidence of benefit in early pregnancy. As with many of the changes recommended for self-use of abortion pills, they say regarding anti-D immunoglobin:

> *"The challenge for current abortion providers is changing a time-honored clinical practice with dubious benefits."*

The bottom line: Who controls the pills? Who should control them?

The bottom line is that the move to self-managed abortion requires a permissive law, an accepting health system, and supportive health professionals, especially at senior levels of the health system and among obstetrician-gynaecologists. Otherwise there is a risk that it may remain the privilege of those who find out how to do it safely without delay.

There is no doubt that abortion with pills has so simplified first trimester abortion that obstetrician-gynaecologists are to a large extent obsolete as first-line providers. That does not mean there is nothing left for them to do, as Prof Aníbal Faúndes insisted recently. (Personal communication at: Bringing the WHO recommendations on safe abortion and family planning closer to women in countries of Eastern Europe and Central Asia. Chisinau, 15–16 November 2018). D&E and other later abortions, complicated cases for medical reasons, complications from unsafe abortion, training of mid-level and primary level providers, involvement in policy and guideline development, health system programme development, carrying out of research to improve systems, regimens, methods – all of these and many other ob-gyn problems women experience that have nothing to do with abortion – remain for this cadre. But some doctors just do not want to hand over the power of decision-making over who gets an abortion, and many, especially in the private sector, will potentially lose a lot of income if they can no longer provide most abortions.

Even so, the fact remains (and should underwrite policy) that abortion pills can easily be provided by pharmacists, and both methods of first trimester abortion, aspiration and medical, can easily be provided by community and mid-level providers – nurses, midwives, general practitioners – instead of senior doctors. Pre-abortion checks can be done via phone, skype, or computer, making multiple visits to a clinic let alone a hospital clinic history, as long as the deeply institutionalized insistence on an ultrasound scan to date the pregnancy can be removed. The fact that Canada has successfully instituted this policy in 2018 gives hope that others may (eventually) follow suit [22]. In some cases, multiple visits were only imposed for punitive reasons anyway, such as the three-to five-day waiting period between "requesting" an abortion and "receiving" it.

Abortion with pills using both mifepristone and misoprostol can be initiated as soon as a woman knows she is pregnant, even before 6 weeks LMP [23]. A 2017 FIGO Guideline has also shown that with misoprostol alone, additional doses (depending on length of pregnancy) can achieve close to 100% efficacy [24]. In the many countries that have refused to approve mifepristone so far, this means use of the FIGO dosage/regimen can reduce much of the need for additional treatment for completion of abortions. It is therefore disappointing that the regimen in the combi-pack of mife + miso (one 200 mg mife pill and four 200 μg of misoprostol) produced by the Concept Foundation cannot be altered to include additional misoprostol doses in case they are required, because it would need a whole new, very costly registration process. (Personal communication, Hans Vermer, at: Bringing the WHO recommendations on safe abortion and family planning closer to women in countries of Eastern Europe and Central Asia. Chisinau, 15–16 November 2018). Norway and Sweden have already shown that medical abortion means abortions are earlier, and that the cost to the health system is substantially reduced. Self-managed abortions are likely to reduce costs even more, especially if the price of the pills is controlled.

But senior ob-gyn doctors are used to setting the terms of abortion provision and controlling who gets what services, when, and where. It is they who most stand in the way of the WHO guidance that recommends task-shifting from senior to mid-level providers, published in 2015 [13]. Yet it is the shift from the 20th century way of doing things that would allow these changes to be implemented overnight.

It is worth pointing out that the ethos of self-use has quickly gained ground in the contraception field. A special edition of Contraception presents research on a subcutaneous formulation of the widely used injectable Depo Provera, somewhat different from the injectable version, which can be delivered by community health workers as well as through self-injection by women. The overview of the key findings of the research shows how apparently easy it is for an existing contraceptive method with some significant changes in dosage and delivery to be registered in 33 countries, with approximately one million doses used in introductory research studies, even while studies of its safety, efficacy and acceptability are still being published. It also shows how provision by medical and nursing students and other community health workers, not to mention self-injection by women themselves, has already been accepted and promoted. Compare this to medical abortion pills. Since 1988, 30 years ago, only about 60 countries have registered mifepristone. Moreover, self-use is still described as dangerous by people who should know better and is criminalized in many jurisdictions. Thus, a contraceptive method that gives women autonomy over their bodies and their fertility is praised and promoted, while an abortifacient is withdrawn, withheld and sometimes even criminalized [25].

False news: self-managed abortion is dangerous

Despite the fact that abortion has been legally available in Britain for just over 50 years, there are still many health professionals who claim that self-use of MA pills is downright dangerous, and they argue that access to the pills should be strictly controlled. Several women have even been put into prison for using the pills outside a health system setting and one for selling the pills to customers in her shop. In 2012, for example, a woman with several small children was unsuccessful in finding anyone to help her have an abortion after 24 weeks of pregnancy (she tried at least two clinics) and then spent weeks trying to find medical abortion pills online before she successfully self-managed a very late abortion. She was prosecuted under the 1861 Offences against the Person Act and was sentenced to eight years in prison by an apparently anti-abortion judge. I agree with the journalist who covered this

case, Simon Jenkins, when he said: “It's judicial machismo that jails women like these. The harm done to society… far outweighs their crime; in this, Britain is medieval” [26]. A second woman was prosecuted similarly several years later and was given a three-year jail sentence. The first woman appealed and had her sentence reduced to three years.

In June 2015, a woman was jailed for 27 months for selling medical abortion pills to customers in her ayurvedic shop in London. The press release about this case by the Medicines and Healthcare Products Regulatory Agency used the language of the 1861 Act to describe her crime as being: “with intent to unlawfully procure miscarriages”. The Agency and the police were apparently alerted after several women attended a hospital for complications though there was no independent information about what those complications actually were. The Agency's press release warned: “Selling mifepristone with no medical qualifications is illegal and can be extremely dangerous for patients.” [27] This was of course repeated by the media, mostly without question. It's not just in medieval Britain that women have been prosecuted for self-use of medical abortion pills. It has also happened in the USA, Northern Ireland, the Irish Republic and Australia.

But while it is more than fair enough that health professionals are concerned about how and by whom complications and mistakes are handled, as they are often the ones who have to shoulder the responsibility, it is unacceptable to demonize self-use of medical abortion pills.

In fact, the WHO 2015 guidelines effectively say that self-use of mifepristone + misoprostol obtained from someone with knowledge and training – a gynaecologist, GP, nurse, midwife, pharmacy worker or the woman herself – is safe as long as the pills are bona fide and good quality, women have information on correct use and have access to back-up if needed. But knowing how many decades it took in the so-called developed world to allow women to buy birth control pills and emergency contraception over the counter, we can expect implementation of WHO's wisdom to be a slow, long-drawn out affair, with much posturing and little progress.

What about self-managed second trimester medical abortion?

Most people raise their eyebrows in horror if you mention that some women are managing second trimester medical abortion at home. Yet every day, many women who seek abortion after the first trimester in clandestine situations are failing to get the help they need and are forced to continue the pregnancy to term. In some countries, such as Senegal, that has led to infanticide [28]; in others, to very unsafe procedures, morbidity and death.

In response to this situation, a network of women was formed in Argentina called Socorristas en Red, who offer a model of accompaniment in which they provide information and support to women self-managing second-trimester abortions at home. The model consists of four stages: 1) a telephone hotline for initial contact, listening to what women need; 2) a group meeting where women in need of abortions meet with several Socorristas and are given information based on WHO protocols, protocols from the Latin American Federation of Obstetrician-Gynecologists, and the experience of the Socorristas; 3) telephone support during the abortion from one of the Socorristas who was at the meeting and help to access care if required; and 4) post-abortion follow-up by a trained clinician. The group acknowledges in their report that studies to evaluate the safety, effectiveness or acceptability of second-trimester abortions using this model are sorely needed. Since then, they have done such an evaluation, which hopefully will be published soon [29].

What else is problematic and needs improving

Pathways to obtain/use abortion pills (mainly only misoprostol) in legally restricted settings are complicated and fraught with unknowns. Even so, self-use of these pills began to reduce deaths from dangerous methods as early as 1989 in Brazil [30]. However, as long as abortion remains clandestine, it isn't as safe as it should be. Even though misoprostol is available in almost all countries, it may still be approved only for gastric ulcer treatment, not for abortion. Hence, the package insert will not give any information on how to use it safely and effectively for abortion. This is a major public health failing when few governments can claim not to know how extensively it is being used, and are even willing in some cases to provider post-abortion care for complications afterwards.

Quality and efficacy of pills need to be assured. Given the enormous role of the internet in the sale of an endless list of pills and devices, this is very complicated. It is an important reason, however, why governments need to approve one or more brands of these pills, on public health grounds. Moreover, supplies need to be regular, and dosages and regimens need to be known by providers and women for different stages of pregnancy. Until mifepristone and misoprostol can be registered and approved for induced abortion and made widely available through health services and pharmacies, however, we can only try to ensure that women get the information they need from other sources – e.g. hotlines, websites, leaflets, social media. This is what the women's health and rights movement is doing its best to accomplish.[1]

What about vacuum aspiration and surgical abortion?

The current debate around medical abortion pills sometimes fails to address the consequences for aspiration and surgical methods of self-management of abortion with pills. This is a mistake, both because there are women who prefer not to use pills, partly because of the time it takes and partly because not everyone is in a position to have an abortion at home. It is also a mistake in that the loss of skills in provision of these methods may create new problems. If we fail to acknowledge and act on this, we are failing to understand the hard-won lessons of not imposing one contraceptive method on everyone, e.g. because it is long-acting, has a low user failure rate and/or is cost-effective.

Two years ago, I invited abortion providers from seven countries: Norway, New Zealand, Australia, Spain, Colombia, Mexico and Brazil to respond to the question: What if medical abortion becomes the main or only method of first-trimester abortion? Their answers were revealing: in Norway, for example, medical students are no longer learning how to do aspiration for uterine evacuation and are sometimes causing perforations and incomplete abortions. This should pull everyone's socks up. Several other providers thought medical abortion was the future, what women wanted, the “most awaited pill”. Other major benefits mentioned included “[it] reduce[s] social injustice stemming from inequality of access to health services, and compensate[s] for the decrease in the number of abortion providers that we are seeing everywhere”. These are critical issues. Still, all of them believed that “no one method for abortion should be the only method”. Looking to the longer term future, two talked about “a future when women will be empowered to take a rapid decision when confronted with a delayed menses, purchasing and taking medication to “recover menses” without either the knowledge or intervention of anybody else — unless they wish it” and “provide women with the means to take all their own reproductive decisions” [2].

This perspective calls for a more nuanced and complex discussion of what sort of abortion service is needed in different country settings, who the providers should be and what their training should consist of in the wider context of sexual and reproductive health care more broadly, and where abortion services should be situated. In this, WHO guidelines provide both evidence and experience. It is past due time for countries to follow them.

Summary

Towards a consensus: Marrying self-use and access to health care

A study published in 2017 in the BMJ looked at self-reported outcome data submitted to a telemedicine clinic by 1,000 women four weeks after receipt and use of mifepristone and misoprostol to end an early pregnancy in Northern Ireland and the Republic of Ireland. Almost 95% reported successfully ending their pregnancy, 0.7% required a blood transfusion, 2.6% required antibiotics, and overall 9.3% experienced symptoms potentially requiring medical attention. There were no deaths. The study showed, according to the accompanying editorial, that “women in jurisdictions with severe restrictions on abortion but good access to high quality healthcare will self-assess and manage po-

[1] Details of abortion information hotlines around the world can be found at: http://www.safeabortionwomensright.org/safe-abortion-3/safe-abortion-information-hotlines/.

tential complications" and that "the findings are consistent with abortion outcomes in face-to-face and telemedicine settings where abortion is legal". The editorial continues: "Aiken and colleagues report the best safety evidence to date for self-sourced medical abortion through telemedicine for women living where high quality healthcare is accessible but legal abortion is not." Although the findings are limited by the fact that almost a third of women who used the telemedicine service did not report outcome data, a high proportion did so compared to other studies [31].

In very good conditions, one in ten women experienced symptoms potentially requiring medical attention. While it is unlikely that any serious event will happen that cannot be taken care of in a good health system, the same may not be the case where access to care is limited or non-existent. Hence, service delivery should include both allowing self-management and good access to (post-)abortion care if and when required.

A consensus position might be this: the evidence all shows that while women want the support and back-up of a health professional if and when they need it, which is exactly what public health services should provide for them, they are also keen to self-manage their abortions using pills. They are also very happy to obtain the pills locally from a pharmacy or a mid-level provider or via telemedicine. If only the law, the politicians, the health system and senior medical professionals in every country were willing to make it happen – it would be so simple.

Practice points

Women want the support and back-up of a health professional if and when they need it, and that is exactly what public health services should provide for them. They are also keen to self-manage their abortions using pills, and obtaining the pills locally from a pharmacy or a mid-level provider or via telemedicine. If the law, the politicians, the health system and senior medical professionals were willing to make that happen – it would be so simple.

Research points

In very good conditions, one in ten women self-managing abortion with pills experienced symptoms potentially requiring medical attention. In countries with good health care systems that include abortion care, it is unlikely that anything serious will happen that cannot be taken care of, but the same may not be the case in countries where post-abortion care is limited or non-existent. This calls for a service delivery situation in which self-management and access to (post-)abortion care are both optimum. Research in a range of different country settings could indicate what, by which cadre and where that care should be available.

Conflict of interest

None.

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