

Editorial

Medical abortion pills have the potential to change everything about abortion

Medical abortion (MA) pills (mifepristone + misoprostol) have the potential to change everything for the better for women who need an abortion. The abortion takes place in the woman's body. It is not "carried out" or "conducted" by someone else. Thus, the method — in itself — has the potential to give women greatly increased autonomy. High levels of safety and efficacy have been shown up to 22 weeks of pregnancy [1]. Research by Gynuity Health Projects and others has shown that women can use the pills at home safely up to 10 weeks LMP, a usage which was approved by the US Food & Drug Administration in March 2016 [2]. In addition, a growing number of telemedicine services from the Netherlands to Australia [3], as well as the success of safe abortion information hotlines in more than 20 countries in the global south [4], have shown that in the first trimester women can follow simple steps to have a safe medical abortion. These involve consulting a trained person, who does not need to be a health professional, by phone or by internet to confirm they are eligible to use MA safely; learning how to use the pills correctly; obtaining the pills from a provider, a pharmacy, or other bona fide source; obtaining information about expected side effects and signs of complications, how to manage them and when to seek clinical help. Women are then able to use the pills safely and effectively at home, contacting the provider or hotline if they have questions or concerns during the process or afterwards. Finally, women are able to check they are no longer pregnant using an appropriate pregnancy test, and go for follow-up care if they believe they may still be pregnant or are unsure, and/or have experienced complications.

Where MA pills are available as soon as women suspect they are pregnant, for example, in developed countries like Norway [5], abortions have become substantially earlier. In Nepal too, as the study by Tamang et al. in this Special Edition shows, the majority of women who went straight to a pharmacy for MA pills to use at home were less than 6 weeks pregnant (70%) and a further 27% were less than 10 weeks. None of the women in that study had complications with pill use [6]. Moreover, as shown in the systematic review undertaken by Kapp et al. for this Special Edition existing research "supports the use of medical abortion at gestational ages <42 days". [7] Efficacy rates were found to be high

overall and appeared to reflect rates observed during the 7th week of pregnancy. In short, women can initiate MA use as soon as they suspect or discover they are pregnant.

MA use is not problem free or perfect. But almost all of the problems that are arising for women having an abortion with this method, problems clearly shown in some of the papers in this Special Edition, are occurring in countries with very restrictive abortion laws and poor or non-existent services. This is not the fault of the pills, though the pills are often blamed. Rather, it is restrictive laws and policies that have a number of consequences – women are forced to act in secret and clandestinely; they have little or no access to trained MA providers; inadequate knowledge even of what the medications are or if they are the right ones; lack of access to one or both medications at an affordable price; lack of information on how to use the pills safely and effectively; and inadequate help if and when they need it.

These papers show that women in many countries are using or trying to use MA pills on their own, and if they experience problems, they find help, though not always the most effective or appropriate help. Yet, no one has any idea how many of the women seeking help actually needed help, nor whether they needed the surgical treatment they often received. This research remains to be done.

In some legally restricted settings, such as Chile and Argentina, women are using MA pills at home clandestinely and successfully. In Chile, where at least some women do have access both to pills and good information, they are using the pills at home clandestinely and making use of the healthcare system as needed, as the paper by Irma Palma Manríquez et al. in this Special Edition shows [8]. In Argentina, as the Zurbriggen et al. paper shows, a feminist network offers a model of accompaniment for women in the second trimester to use MA at home [9].

In places where the best conditions for MA use prevail, there is no need for a follow-up visit in most cases, let alone post-abortion care. Medical abortion in optimal conditions means that the role of obstetrician-gynecologists can effectively disappear from abortion care, with the exception of complicated pregnancies. They can be replaced by trained midwives and nurses, family planning providers and pharmacy workers after a simple training course, as the

papers in this Special Edition from Nepal by Tamang et al. [6] and Kyrgyzstan by Johnson et al. show is possible [10]. Such research confirms that WHO's 2015 guidelines on allowing trained mid-level providers to manage almost all abortions [11] actually work in practice and should be implemented universally.

With the exception of Zurbriggen et al. [9], the papers in this Special Edition are not about second trimester abortion with MA, whether in a clinical setting or a clandestine one, though some of the women interviewed in these studies did indeed obtain and use MA pills in the second trimester. Information on how safely women in legally restricted settings are using MA pills for second trimester abortion is almost non-existent so the Zurbriggen paper is an important contribution, albeit a limited one due to small numbers. Second trimester medical abortion is a subject that deserves far more attention in general, not least because there are so few doctors trained to do dilation & evacuation abortion. Without second trimester MA, outdated surgical methods, long removed from the WHO list of recommended methods [12], are still being used, with little or no effort at national level to replace them.

With optimal use of MA, the costs of abortion to health systems in every country could drop substantially, as the paper by Lince-Deroche et al. from South Africa, in this issue, shows [13]. Very early abortions could also become the norm, because that is what women prefer and what is in their best interests.

Yet, as the papers in this Special Edition show, the distance between this vision of what is possible with the use of MA pills and the reality for very many women seeking abortions today is immense. The failure even to come close to this vision is an indictment of the many countries that have failed to embrace technical developments in abortion care and to implement crucial WHO guidelines on evidence-based practice [11].

1. The papers and some perspectives on the future

The papers in this special edition of *Contraception* report on the use of MA pills in Argentina, Bangladesh, Benin, Burkina Faso, the Burma-Thailand border, Chile, Kyrgyzstan, Madagascar, Nepal, South Africa and the UK. In addition to the papers already mentioned, there is a paper on research gaps in relation to MA, a commentary by two of the founders of Women Help Women on putting MA pills directly into women's hands in order to achieve the full potential of the method, and a roundtable of views from health professionals in seven countries and whether they think medical abortion should become the main or only method of first trimester abortion.

It has been over a year since we first put out the call for papers for this special edition. It was well worth the wait. The papers have revealed both what we hoped, and in some cases what we feared. On the one hand, they show the incredible

potential of MA pills to give women a very safe method and autonomy in relation to abortion. On the other hand, they show the sometimes serious problems women are experiencing – incomplete and failed abortions; and complications of heavy bleeding and infection – when they do not know how to use MA pills correctly or do not even know what kind of pills they have actually used. However, although women's experiences were sometimes negative, they did manage to have an abortion and got treatment when they needed it though we cannot generalize beyond these papers.

All the confirm a growing awareness in the field that MA pills are now very easy to obtain almost everywhere; and that at least some women know of their existence and go looking for them when they need an abortion, no matter where they live, even in the most remote and rural areas of the poorest countries. In the poorest countries, however, access to information about the pills and how to use them has lagged far, far behind.

Importantly, these papers also reveal how little many health professionals and pharmacy workers appear to know about the correct use of MA pills, and this seemed to be more problematic the poorer the country. Pharmacies and the internet are often the first place women go for MA pills, and both are highly acceptable sources to women.

Finally, the papers reveal that in the poorest settings, where women are obtaining pills from completely unofficial sources, they have no way of knowing whether the pills they are buying are bona fide or not, and they may well not be.¹ In the many countries where misoprostol is available over the counter for other indications but is not approved for induced abortion, the package insert does not give women seeking abortion the information they need. Thus, as a stopgap, until and unless both mifepristone and misoprostol can be registered and approved for induced abortion and made widely available through the health services and pharmacies, healthcare providers and advocates can only try to ensure women get that information from other sources, whether via telemedicine, safe abortion information hotlines, websites, leaflets, or social media. This is far better than nothing and has helped to reduce deaths from dangerous abortion methods since the 1990s, but as long as abortion remains clandestine, it is not good enough.

2. Conclusion

These papers have opened a window on what is happening with medical abortion pills in a range of countries in all world regions, but especially in the global south, and they are full of crucial signposts for action. We look forward to similar research in many more countries, and to the day when findings like these are no longer ignored or pushed

¹ See, for example, the Samsara Indonesia website list of recommended sources of misoprostol vs. known scam pill-selling sources in Indonesia alone: <http://askinna.com/jangan-mau-ditipu-penjual-obat-penipu/>.

aside by those with the power to effect change, especially those who profess to support women's reproductive health and rights – except when it's about abortion.

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