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MEDICAL ABORTION MATTERS

Sharing global perspectives since 2009

INNOVATIONS: *Out of the fire of anger: A women's center in Tanzania opens a pharmacy to bring misoprostol to rural communities*

When the staff of the Women's Promotion Center (WPC) in Tanzania's rural Kigoma Region realized women were suffering and dying unnecessarily from unsafe abortion—and that misoprostol could provide an option for safe abortion if only it was available—they got angry. So they started a pharmacy to bring misoprostol to local communities to save women's lives.

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RESEARCH WITH IMPACT: *New findings support both outpatient medical abortion up to 10 weeks gestation and home use of mifepristone*

Service delivery norms and practices for medical abortion have traditionally created barriers to wider use. Among the most significant barriers is the fact that the method is usually available in outpatient service up to only 63 days (nine weeks) since a woman's last menstrual period—and that women are required to start the procedure by taking mifepristone the day they visit the clinic. But two new studies published by [Gynuity Health Projects](#) stand to greatly expand women's access.

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WHAT MATTERS TO YOU?

Question: Can medical abortion be used in the second trimester?

Answer: Yes, abortion using a combination of mifepristone and misoprostol—or a misoprostol-only regimen if mifepristone is unavailable—is safe and effective in the second trimester.

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COUNTRY MATTERS: *Misoprostol for postabortion care in Nigeria: Changing policy and preparing for action*

Before 2009, providers and women in Nigeria had little to no knowledge of misoprostol's use

in postabortion care (PAC), the drug's availability was very limited, and there was no federal endorsement or standards and guidelines for the use of misoprostol in PAC. But this situation changed when research and advocacy led to a new policy on misoprostol, which has been key to expanding use of the drug.
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PERSPECTIVES: 'Medical abortion is revolutionary': Samsara's Inna Hudaya on abortion access in Indonesia

In 2008, Inna Hudaya helped found [Samsara](#), an organization in Indonesia dedicated to promoting sexual and reproductive health and rights (SRHR) education and information, including safe abortion. One of Samsara's main programs is a national safe abortion hotline. In a recent interview, Hudaya explained that the increasing availability of misoprostol has revolutionized how she and her colleagues assist women.
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FEATURED ORGANIZATION: Ecuador's Coordinadora Juvenil por la Equidad de Género (Youth Coordinator for Gender Equity)

Run by young women and men aged 18–26, Ecuador's Coordinadora Juvenil por la Equidad de Género (Youth Coordinator for Gender Equity) aims to build a world where women—especially the youngest, poorest and most disadvantaged women—can make safe decisions about their bodies and their lives. The organization supports the hotline Salud Mujeres (Women's Health), which offers supportive counseling and free, reliable information on sexual and reproductive health, including information on contraception and on how to safely terminate a pregnancy—if a woman so chooses—using misoprostol pills, which are available in Ecuador but not always easy to obtain. Learn more about the organization via its Spanish-language [blog](#) and on [Facebook](#).
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RESOURCE SPOTLIGHT: Ipas's new Clinical Updates in Reproductive Health

Ipas's new *Clinical Updates in Reproductive Health* provide up-to-date, evidence-based recommendations for abortion care—in both English and Spanish. Generally reflecting guidance in the World Health Organization's 2012 *Safe Abortion: Technical and Policy Guidance for Health Systems, Second edition*, the Clinical Updates are revised twice a year to bring you Ipas's most up-to-date clinical guidance. The easy-to-navigate format also notes for each topic the quality of evidence, strength of recommendation and date of last review. Content on medical abortion (MA) includes dosage and regimens in the first and second trimester, eligibility, pain management, contraception after MA, abortion method comparisons, product quality, home use of MA, misoprostol for postabortion care and more. You can access the most recent document at www.ipas.org/clinicalupdates and in Spanish at www.ipas.org/actualizacionesclinicas. To suggest new topics, write to us at clinicalaffairs@ipas.org.



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'Medical abortion is revolutionary': Samsara's Inna Hudaya on abortion access in Indonesia

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'Medical abortion is revolutionary': Samsara's Inna Hudaya on abortion access in Indonesia

In 2008, Inna Hudaya helped found [Samsara](#), an organization in Indonesia dedicated to promoting sexual and reproductive health and rights (SRHR) education and

information, including safe abortion. One of Samsara's main programs is a national safe abortion hotline.

In a recent interview, Hudaya explained the hotline previously focused on helping women find safe abortion providers, but the increasing availability of misoprostol has revolutionized how she and her colleagues assist women.

Why did you decide to start Samsara and what is its mission?

Hudaya: I had an unplanned pregnancy 10 years ago. I



Inna Hudaya, an advocate for sexual and reproductive health and rights in Indonesia, helped found the organization Samsara to provide women with information on safe abortion.

was young, lacked information about safe sex, had no access to contraception and no support in deciding anything about my sexual and reproductive health choices. Without understanding my choices and the consequences, I decided to have an abortion when I was six weeks pregnant. I wish I had reliable information and support—then I wouldn't have had to deal with unnecessary depression afterward. I was emotionally, financially and socially bankrupted by fear and stigma.

That's why I decided to start Samsara. Originally it started as a [blog](#) where I published my abortion story and translated many articles about abortion into Bahasa Indonesia, the national language. I wanted to make sure that women have enough reliable information to make informed decisions. In less than a year, I had received many emails from women in Indonesia who experienced the same situation I did; that's how Samsara grew. The mission is to provide reliable information and support for women with unplanned pregnancies and for women who have had abortions. We also strive to bring the "A word" into public discussion. For us, sharing is empowering, and the personal is political.

Editor's note: To see Hudaya tell the story of how she founded Samsara, [watch this video](#).

What is the legal situation regarding abortion in Indonesia? Do you have any problems with the law when Samsara offers counseling about abortion?

Abortion is illegal except to save the life of the woman, and in cases of fetal impairment or rape. But even though abortion is legally restricted, it is actually very common in Indonesia. So far we have had no problems with the law, probably because Indonesia's government doesn't consider sexual and reproductive health an important issue—they just don't care about it.

Where and how does your hotline operate?

It's national, so we operate all over Indonesia. And we sometimes also receive emails and calls from Southeast Asia—places like Malaysia, the Philippines, Thailand and India. We offer counseling, and the phone hotline is one of the media we use, but we also have a website with an online form women can fill out and submit to us. In addition, women can email us or come visit our office if they live in our city. We respond to emails 24 hours a day, but the hotline is open Monday to Friday.

More than 80 percent of our callers find out about us on the Internet, so when we started the hotline we did not do much promotion—we only used social media for dissemination. I started my blog in 2007 because there's not enough reliable information in Bahasa Indonesia (our language) on the Internet. But if you Google "abortion" in Bahasa, there are so many search results. In the last few years, my goal has been for Samsara to show up in the first page of Google search results—which it now does. It's quite interesting because from 2007-2009 we found that most women found us by searching the keyword "abortion," but since 2009, most people find us with the search terms "safe abortion" or "where to find safe abortion."

How does Samsara incorporate medical abortion (MA) into its work?

Samsara's hotline started in 2008. At that time we helped women access surgical abortion by mapping out the clinics that would provide abortions, advising on how to deal with doctors and how not to get cheated, etc. The biggest challenge was that only if you are educated, rich and live in a big city can you access those clinics easily. It breaks my heart that most women have had to go through discrimination and violence to access safe abortion.

We integrated MA into the hotline in 2011. We were in

contact with Women on Web, and they came to Indonesia and gave us training on medical abortion, so that's how we got started. And I would say that MA is revolutionary. It has had a big impact for women in general and for Samsara specifically. Now we receive fewer stories from our clients about how they went through discrimination and violence to access abortion. With MA, women become the doctor for themselves; they can do it at home safely and fully have control over it.

For a country like Indonesia, where most women aren't well informed about their health and bodies, MA also educates women to be more aware of the changes and signs in their bodies during and after the abortion. For most clients, this experience is a starting point from which they begin to exercise knowledge about their own bodies.

Does MA now comprise the majority of your counseling?

Yes, it's mostly medical abortion now. Most women with unplanned pregnancies who contact us are unmarried and have mid- to lower-level incomes, so they don't have access to contraception and that's why they're facing unwanted pregnancy. That's also why most of them choose medical abortion—it's cheaper. Privacy is also a factor. In a country where abortion is legally restricted, privacy and security are the most needed.

How do you advise women to access MA in Indonesia?

Women can access misoprostol in pharmacies as a medicine for gastric ulcers. Usually it's easier to access in small cities and drug stores as opposed to big cities and big pharmacies. Misoprostol is also available over the Internet, but this is risky. Many women report they get cheated; they send money but the medicine never

arrives, or the medicine arrives but has no effect.

We tell women the highest price that is acceptable for a seller to charge; we also tell women the name of the brands to ask for. One barrier is that if you go to a pharmacy and say you need misoprostol for a gastric ulcer, the maximum amount they will give you is three or four pills, so women have to find at least three pharmacies and get four pills from each pharmacy—or use the same pharmacy but first the woman visits, then maybe her boyfriend, and then perhaps a friend. So it's quite tricky.

Another problem is medical abortion protocol. Many drug sellers on the Internet do not provide women with the right protocol. And for doctors, many of them give women only enough misoprostol to start a miscarriage so the women will come back to them and pay more for a uterine evacuation. It's legal for the doctor to do this because abortion is legal if the woman presents with a miscarriage. So doctors know how to use medical abortion, they just don't want to give the right protocol.

The availability of misoprostol helps women access safe abortion, but reliable information and counseling take an important role in ensuring that women know how to do it by themselves. In my opinion, the definition of safe abortion needs to be changed: It's the combination of a woman's choice, reliable information and medical treatment only if needed.

Can you explain further what you mean when you say the definition of safe abortion needs to be changed?

Before I always thought that safe abortion is like everyone says: performed by a doctor in a clinic, and then it's safe. But our experience shows that it's safe for women to do it themselves as long as they have reliable information. Sometimes, even if a woman goes to the doctor, he or she will not give you any

information about what is happening in your body. So for me, with medical abortion, you give back this authority to the hands of women. They can become the doctor for themselves as long as they have the information, the right protocol, and knowledge of normal side effects and when to seek medical treatment. Women are very smart, strong and capable of doing this. If they don't need medical treatment, why should they pay for it?

In the future, what do you hope Samsara will accomplish?

I wish to see more women able to access our hotline. Our biggest challenge is to reach more women in rural areas who do not have access to the Internet.

I also want to see Samsara be a model for MA hotlines. Working on an abortion hotline is not easy, and people who do this work are at risk of burning out. It takes hard work and guts to do it. But it's very powerful because hotlines can reach the grassroots. Therefore, I want to create a system that can help hotlines work more effectively and efficiently and place fewer burdens on the counselors.

I'm working now on the concept of a hotline model that includes how to manage resources and how hotlines can work more efficiently and effectively within a tight budget, and hopefully this can be helpful for other hotlines. We have shown the world that funding and resources are not limitations when you really believe in something. Most women who work on hotlines have passion for and interest in this issue, but the job is quite difficult. .

Do you have plans to advocate changing Indonesia's abortion law?

I do believe in advocacy, but pregnant women cannot wait for that. Pregnant women cannot wait for the law to change, so I think hotlines can offer the change they need. Hopefully we will see law change in the future,

but I'm not thinking it will change soon. I believe advocacy to change the law must go along with advocacy to change society. What we do now is work to change society's perspective on abortion. We talk about abortion in public, about abortion stigma and how this can affect women, their families and society. Even if the law changes, if society is not ready for it, then there will be no true change. I think it's better that other organizations and networks work to change the law, and for Samsara to work to change our society —so when the law changes, society is open and ready for that. That would be great.

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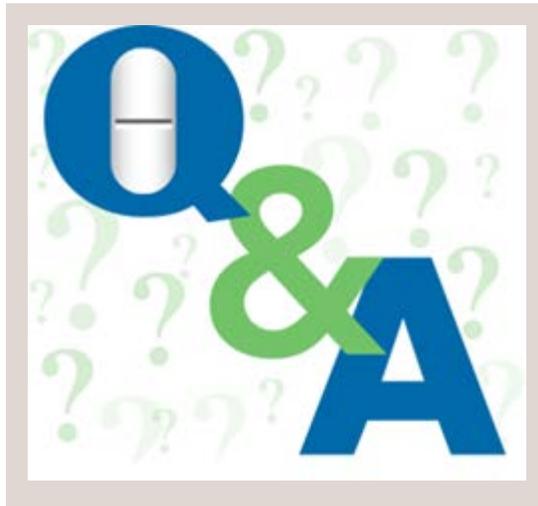
Is medical abortion really acceptable for use in the second trimester?

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Can medical abortion be used in the second trimester?

Yes, abortion using a combination of mifepristone and misoprostol—or a misoprostol-only regimen if mifepristone is unavailable—is safe and effective in the second trimester.



Where both dilatation and evacuation (D&E) and medical abortion are available, women who are eligible should be offered a choice. In settings where D&E isn't offered, medical abortion is a safe and effective option for second-trimester abortion.

The following recommendations are for clinic-based procedures, and are the same for young women as for adult women.

Second-trimester abortion with mifepristone and misoprostol

The recommended regimen for women who are 13-24 weeks gestation is mifepristone 200mg by mouth,

followed 36-48 hours later by misoprostol 800mcg vaginally for one dose, then 400mcg vaginally or sublingually every three hours for four more doses.¹

If medical or social issues require a shorter time interval between taking mifepristone and starting misoprostol, the interval may be shortened or the medications started simultaneously. Even if mifepristone is taken at the same time as misoprostol, the combined regimen is more effective than misoprostol alone.²

Expulsion rates

In the largest cohort study of 1,102 women having second-trimester medical abortion using the recommended mifepristone and misoprostol regimen, the complete expulsion rate was 98.3 percent at 24 hours and 99.2 percent at 36 hours.³

Induction-to-abortion interval

In the cohort study mentioned above, the median time to fetal expulsion was 6.25 hours, with a range of 0-67.5 hours. The induction-to-abortion interval was longer in nulliparous women, older women and women at a later gestational age.³

Complication rates

The rate of major complications from mifepristone and misoprostol medical abortion in the second trimester is low, although minor complications—such as needing a procedure for bleeding or retained products of conception—are more frequent than from D&E.⁴ In the cohort of 1,002 women, 81 women (8.1 percent) needed surgery for uterine evacuation, the majority for retained placenta. Only two out of the 1,002 women needed a surgical evacuation to terminate the pregnancy.³ In this study, serious complications such as hemorrhage, blood transfusion or unanticipated surgery occurred in eight women (less than one percent). In a meta-analysis of studies of medical

abortion, the overall rate of uterine rupture is 0.08 percent, with a rate of 0.28 percent in women with a previous cesarean section.⁵

Second-trimester abortion with misoprostol only

Where mifepristone is not available, misoprostol alone is safe and effective with expulsion rates of over 90 percent at 48 hours, average induction-to-abortion time of around 12 hours and major complication rates of less than one percent.⁶

For women who are 13-24 weeks gestation, the recommended regimen is misoprostol 400mcg vaginally or sublingually every three hours for up to five doses. Vaginal dosing is more effective than sublingual dosing for nulliparous women.^{1,6}

Expulsion rates

In the largest international randomized controlled trial of 681 women having second-trimester medical abortion using the recommended misoprostol-only regimen, the complete expulsion rate was 84.8 percent at 24 hours and 94.3 percent at 48 hours.⁶ The median time to fetal expulsion was 12 hours with a range of 4.1-61.8 hours, with parous women having faster induction-to-abortion times than nulliparous women. Increasing the dosing interval of misoprostol increases the induction-to-abortion time.⁷ Providers should consistently give medications every three hours, even if a woman is experiencing cramps or contractions.

Complication rates

The rate of major complications from misoprostol-only abortion in the second trimester is low, although minor complications—such as needing a procedure for bleeding or retained products of conception—are more frequent than from D&E. In the trial cited above, 12 adverse events (0.02 percent) were reported, with

none of them being serious; 10 women required blood transfusions.⁶

Pain management

Regardless of the regimen used, all women undergoing medical abortion in the second trimester should be offered pain management.¹ Prophylactic non-steroidal anti-inflammatory drugs (NSAIDs) reduce the need for narcotic analgesics during second-trimester medical abortion, and all women should begin taking NSAIDs with their misoprostol. Narcotic analgesics, anxiolytics, and non-pharmacologic measures may be used as needed. If the personnel, monitoring and equipment are available, regional anesthesia or patient-controlled anesthesia may be offered.

For more information on medical abortion in the second trimester, see Ipas's new [Clinical Updates in Reproductive Health](#).

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Misoprostol for postabortion care in Nigeria: Changing policy and preparing for action

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Misoprostol for postabortion care in Nigeria: Changing policy and preparing for action

Before 2009, providers and women in Nigeria had little to no knowledge of misoprostol's use in



postabortion

care (PAC), the drug's availability was very limited, and there was no federal endorsement or standards and guidelines for the use of misoprostol in PAC. But all that has changed following research and advocacy that led to improved policies, which are the foundation for expanded use.

Before: Limited options for women who needed PAC

Unsafe abortion is a persistent problem in Nigeria, where the total fertility rate is 5.7 and the modern contraceptive prevalence rate is 15 percent, according to the 2008 [Nigeria Demographic and Health Survey](#). In fact, a [survey conducted from 2002-2003](#) in 33 hospitals across Nigeria found that of the 2,093 women admitted for abortion-related reasons, 36 percent

presented after attempting to end their pregnancy (24 percent of whom had serious complications) and 32 percent were treated for complications of miscarriage. The same study estimated that at least 3,000 women die in Nigeria every year from unsafe abortion, and other estimates have put the number as high as 34,000. Abortion is illegal except to save a woman's life, and many women seek unsafe, clandestine procedures that result in complications.

As of 2009, Ipas had been working in Nigeria for more than 20 years to improve the quality of PAC and expand and decentralize care alongside a wide range of stakeholders—including the federal government, the Society of Gynaecology and Obstetrics of Nigeria (SOGON) and women's and community groups. A survey of obstetricians and gynecologists documented very limited knowledge about the indications for and regimens of misoprostol, and a [survey of pharmacies](#) documented limited availability of misoprostol.

"Even if providers were using some regimen of misoprostol for PAC, it was not a significant number—maybe only a few," says Sikiratu Kailani, a senior health systems associate with Ipas Nigeria.

At the same time, studies from other countries and regions were proving that misoprostol was a safe and effective medication for treating incomplete abortion and could be incorporated into a comprehensive PAC model. Ipas Nigeria and its partners recognized an opportunity to improve care for women and tools for health-care providers.

The process: Research informs policy change

"We have seen that a series of steps—involving local research, strategic partnerships and a communication plan—can successfully lead to policy change," explains Ipas Policy Director Charlotte Hord Smith. "A number of organizations and programs are expert in utilizing research for policy change. In Nigeria, Ipas and

partners followed a simple process to achieve policies that expand postabortion care options, and we think this can serve as an example in other contexts.”

Ipas Nigeria, in strategic partnership with SOGON, identified the policy change needed to introduce misoprostol into PAC services: The Federal Ministry of Health (FMOH) would need to endorse use of misoprostol, it would need to be included on the country's Essential Medicines List, and standards and guidelines would need to define its use. Recognizing that international data would not be enough to compel the FMOH and its partners to create such policy, Ipas and SOGON designed a [local feasibility study](#) to pilot misoprostol for PAC in Nigeria and test and document its practicality.

To ensure the data would be broadly compelling, the study included a hospital from each of three different regions of Nigeria—the East, the West and the predominantly Muslim North. Providers interviewed during the study felt the misoprostol regimen was easy to grasp and could be readily introduced into existing PAC services. SOGON led dissemination of these important [study results](#), and the data combined with advocacy efforts influenced the FMOH and its National Reproductive Health Working Group to endorse misoprostol for PAC.

Lesson: Policy change is only the beginning

Misoprostol was added to Nigeria's Essential Medicines List in 2010, and that same year the FMOH and SOGON released a joint statement supporting the introduction of misoprostol for the treatment of incomplete and missed abortion. The FMOH, SOGON and other key stakeholders then worked together to develop standards and guidelines and clinical protocols for misoprostol for PAC.

Once Nigeria's policy changed, the work began to integrate misoprostol for PAC into the country's pre-

existing PAC services. Ipas Nigeria and many other institutions and organizations have made progress in increasing providers' and women's knowledge of misoprostol for PAC, but barriers remain to expanding misoprostol's reach. The standards and guidelines were disseminated to key stakeholders representing the six geopolitical zones in the country, including SOGON members, doctors, lecturers from teaching hospitals, nursing schools, state ministries of health, the FMOH and Ipas staff. Ipas Nigeria also presents highlights from the feasibility study at all trainings they conduct with providers to encourage them to make misoprostol for PAC an available option for women.

"Even now, in spite of the policy change and all our efforts, if you look at the data you'll find that providers are still not using as much misoprostol as one would expect," Kailani says. One specific barrier may be the economic interests of providers, as they may feel they merit a higher fee for performing a procedure than for giving pills to treat incomplete abortion. The lesson: Even with a supportive policy in place, much work remains to turn policy into standard practice so women have more options for treatment.

"Women should be given the power to make a decision about their postabortion care," says Ipas Nigeria Director Ejike Oji. Moving forward, Ipas Nigeria, SOGON and other partners will work to do just that.

For a step-by-step breakdown of the policy change process and more details about Ipas Nigeria's experience advocating for support of misoprostol for PAC, see *Using research for advocacy: Changing policy in Nigeria to support misoprostol for postabortion care*.

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New findings support both outpatient medical abortion up to 10 weeks gestation and home use of mifepristone

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New findings support both outpatient medical abortion up to 10 weeks gestation and home use of mifepristone

Medical abortion can offer a woman the choice to end her pregnancy safely outside the clinic and in the comfort



and privacy of her own home, or a space of her choosing. However, service delivery norms and practices have traditionally created barriers to wider use. Among the most significant barriers is the fact that the method is usually available in outpatient service to only 63 days (nine weeks) since a woman's last menstrual period—and that women are required to start the procedure by taking mifepristone the day they visit the clinic.

Early regimen deemed safe up to 10 weeks

A recent study published by [Gynuity Health Projects](#) demonstrates the effectiveness of medical abortion up to 10 weeks gestation using the regimen previously

recommended only up to nine weeks, thereby expanding women's options for using medical abortion. Most services that offer medical abortion with mifepristone and misoprostol do so up to nine weeks since a woman's last menstrual period. After nine weeks gestation, women are either offered vacuum aspiration or, in the second trimester, medical abortion with repeat doses of misoprostol in a facility. The restriction of the standard regimen to nine weeks limits women's choice of methods.

In a prospective cohort study titled "[Extending outpatient medical abortion services through 70 days of gestational age](#)," published in *Obstetrics & Gynecology*, 729 women with pregnancies of 57-70 days (ninth and tenth week of gestation) in six clinical sites in the United States were given 200mg mifepristone and 800mcg buccal misoprostol—the most common regimen in the United States for abortion up to nine weeks. Women who were in the tenth week of gestation had the same success, complication and ongoing pregnancy rates as women in the ninth week.

The study's authors conclude that women may safely use medical abortion through 10 weeks of gestation. And because the regimen is the same for women up to 10 weeks of pregnancy as for women through the first nine weeks, safe medical abortion services may be offered to more women with no change in the health system. In fact, Mexico City's Ministry of Health has already adopted this regimen as their standard protocol, says Beverly Winikoff, MD, MPH, president of Gynuity Health Projects and a co-author of the study. The findings also demonstrate the benefit of adopting standards and guidelines written with flexible language that can accommodate new research (for example, not limiting a dosing regimen to a certain number of gestational weeks).

"Medical abortion technology has been constantly

evolving,” Winikoff says. “It’s very important that to keep an open mind about this method, because all the restraints and restrictions were developed in a vacuum—people didn’t really know how the method worked in practice. There’s a lot of potential moving forward.”

Home use of mifepristone: Safe and acceptable to women

Extensive practice and previous research have shown that home use of misoprostol following facility-administered mifepristone up to nine weeks is safe, effective, and acceptable to women—and the World Health Organization (WHO) endorses home use of misoprostol. Now, a Gynuity study finds that women can safely use both mifepristone and misoprostol at home. This new practice would allow a woman to start the medical abortion process at a time that’s convenient for her, rather than having the clinic schedule dictate her start time.

In most settings that offer mifepristone/misoprostol medical abortion, women take mifepristone during the clinic visit and misoprostol 24-48 hours later at home. This clinic-initiated schedule may not be convenient for women because of constraints such as school, work or family obligations, and transportation or cost barriers. Allowing women to take mifepristone when they prefer could improve the medical abortion experience by giving them control over when to start the abortion process itself (i.e. the timing of the misoprostol).

In a prospective cohort study titled “[Acceptability of home use of mifepristone for medical abortion](#),” published in *Contraception*, 301 women in the United States were offered the choice of home or clinic mifepristone use, and half chose home use. Women who used mifepristone at home had the same success rates and need for telephone or emergency-room support as those who took mifepristone in the clinic.

Home users were very satisfied with their experiences, and the most common reason women gave for electing home use was flexible scheduling. The study's authors conclude that providers should offer women home use of mifepristone so they can plan when their abortion should take place.

"These findings are probably even more useful than we can document yet, because frequently now, when women call to make an appointment, they're told they should schedule their appointment at a time when they can plan to be able to take their misoprostol pills two days after taking mifepristone in the clinic," explains Winikoff, who also co-authored this study. "If we changed the protocol, we wouldn't have to say that; we could say come to the next available appointment, but you don't have to take the medicine until it's convenient for you."

Furthermore, Winikoff points out, administration of mifepristone in the clinic is not the standard protocol in countries where mifepristone is sold in pharmacies alongside all other prescription drugs. For example, women in Moldova are advised to obtain mifepristone and misoprostol in the pharmacy and use both drugs at home.

Implications for service delivery

Taken together, these two studies stand to greatly expand women's access to medical abortion. If health systems integrated the findings of both Gynuity studies into their service delivery practices—offering home use of mifepristone and misoprostol up through 10 weeks gestation—women would enjoy greatly improved access to medical abortion and the benefits of choosing this option, Winikoff says.

For Ipas clinical guidance on medical abortion regimens and home use of abortion medications, please see our

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Out of the fire of anger: A women's center in Tanzania opens a pharmacy to bring misoprostol to rural communities

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Out of the fire of anger: A women's center in Tanzania opens a pharmacy to bring misoprostol to rural communities

When the staff of the Women's Promotion Center (WPC) in Tanzania's rural Kigoma Region realized women were suffering and dying unnecessarily from unsafe abortion—and that misoprostol could provide an option for safe abortion if only it was available—they got angry. So they started a pharmacy to bring misoprostol to local communities to save women's lives.



Abortion is illegal in Tanzania except to save a woman's life, and unsafe abortion is a significant contributor to the country's high maternal death rate. WPC staff knew many women were dying in the Kigoma communities where they had been working for years on women's

issues like gender violence and economic empowerment. But they didn't have a practical solution to the problem until 2008, when a staff member attended an education session by Women on Web on how to safely use misoprostol.

"After that session, it was clear to WPC that misoprostol—an easy-to-take and easy-to-keep medicine—could prevent postpartum hemorrhage and safely induce an abortion," explains one of WPC's long-time staff members, who chose to remain anonymous. "From there, WPC committed to saving mothers' lives, despite the restricting legal context, by putting information on this life-saving pill into women's hands."

In 2009, WPC launched its "Save Mothers' Lives with Misoprostol" initiative, which began with an education and awareness-raising campaign to prevent unwanted pregnancy and unsafe abortion—and to promote misoprostol as a method for safe abortion and treatment of postpartum hemorrhage.

"Our community facilitators created awareness on the potential of misoprostol, and women started looking for this medicine," the staff member says. "But there was no misoprostol in local pharmacies in Kigoma at that time. It was available in other regions, but was very expensive."

WPC saw an opportunity: Misoprostol is registered in Tanzania for treatment of postpartum hemorrhage. In 2010, WPC opened a local pharmacy that sells misoprostol and also offered counseling by a well-trained professional on how to safely use misoprostol, as well as take-home information about how to use the drug and referrals to doctors willing to help in case of complications.

Since the pharmacy opened, women's access to misoprostol and contraceptives in Kigoma Region has improved, and WPC has noted a decrease in reports of

women dying from unsafe abortion. In addition, the pharmacy's sale of misoprostol created economic competition with private drug sellers in the area and reduced the price from the equivalent of 12 USD to just 5 USD for a package of 12 pills. According to WPC staff, the presence of the pharmacy in Kigoma has also positively influenced rural women's health-seeking behaviors, thereby increasing the local demand for misoprostol.

"What's incredible about this story is that Women's Promotion Center is not a health organization—it focuses on advocacy and women's rights," says Francine Coyteaux, director of the Misoprostol Initiative at the Public Health Institute. "They recognized a health need in their community and took a pragmatic, rights-based approach to solving the problem."

Looking to the future, WPC plans to expand its pharmacy initiative, opening additional small pharmacies in selected towns to provide women with high-quality, affordable misoprostol and contraceptives. Advocacy to change Tanzania's law and grant women access to legal, safe abortion services is also on the agenda. In 2012, WPC began advocacy initiatives that include building a network of local organizations all focused on law change and improving women's access to reproductive health services. After all, advocating for women's rights and against injustice has always been WPC's core mission, and fighting for a woman's right to access a drug that can save her life is a natural extension of that impassioned work.

"The pharmacy initiative was born out of the fire of anger about unnecessary deaths and suffering of women, and also the fire of passion to save mothers' lives in Kigoma," the staff member says. "WPC's enormous determination to prevent deaths due to postpartum hemorrhage and unsafe abortion is the basis of its success in operating the pharmacy."

