

OB/GYN Resident Global Health Education Module

Association of
Academic Professionals in
Obstetrics and Gynaecology



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Case 1: Abortion Access and Post-Abortal Care



Case of SJ



Unsafe Abortion: the preventable pandemic, *Lancet* (2006)

Entails the global burden and morbidity of unsafe abortion, as well as the traditional methods by which these were performed. Also discusses the legal environment of abortion and the associated costs.



Not Yet Rain, *Lisa Russell in association with Ipas* (2009)

Not Yet Rain is a short documentary on abortion in Ethiopia. Through the stories of two women, the necessity for access to safe abortion is explored. <https://www.youtube.com/watch?v=JDPMBq7C1LM>



Abortion Stigma: a reconceptualization of constituents, causes, and consequences, *Women's Health Issues* (2011)

Discusses who is affected by abortion stigma and how this stigma is rooted in cultures, systems, and individuals. Special attention is paid to the stigma towards and burden of physicians providing abortions.



Recent Progress in Canada

CBC Article by Marisa Dragani: RU-486 abortion pill approved by Health Canada (July 2015);
Health Canada Regulatory Decision Summary of Mifegymiso (July 2015)

Case 1: SJ's Journey

SJ, an 18-year old mother of two, travels by bike from her village to an urban hospital in Kenya. She is 10 weeks from her last period and has felt the familiar signs of nausea and breast tenderness of early pregnancy. She sees Dr. D in the outpatient surgical clinic to obtain a vacuum aspiration. SJ was nervous about the procedure, and was even more horrified at the lack of pain control she was given, despite her screams of pain and requests for pain relief.

Dr. D has mentioned to colleagues in the past that far too many women are having abortions. She believes that providing pain relief only encourages women to have more abortions. Although Dr. D professes that she supports legal and safe abortion, she believes that current laws make it too easy for women to terminate pregnancies. Dr. D considers that a little pain during the procedure discourages women from having unprotected sex.

Almost a week post-procedure, SJ develops severe cramping and vaginal bleeding. She reluctantly visits a local clinic where a nurse performs a vaginal examination. The nurse finds what appear to be some retained products of conception. The nurse records SJ's history and physical examination in a hand-written note. She hands SJ an envelope with the note, and then calls for an ambulance to transfer her to the district hospital.

After waiting approximately three hours, the ambulance arrives to take SJ to the district hospital 300 kilometers away. Upon arrival, the doctor reviews the nurse's notes, and asks her "Why did you murder your baby?" He conducts a cursory examination and adds to her medical record. Despite her profuse vaginal bleeding and rapid pulse, the doctor calls for an ambulance to take her to another hospital, which is two hours away. SJ continued to bleed throughout the long ambulance journey and was pronounced dead on arrival at the provincial hospital.

Questions for Discussion

1. What are the healthcare problems in this case?
2. Using the *Integrated Human Rights and Women's Health Checklist*, which human rights are protected or infringed in this case?
3. What are some contributing factors to abortion stigma? What are the consequences of abortion stigma?
4. What are the primary and secondary prevention strategies addressing unsafe abortions?
5. What standards of practice are in place in your healthcare system to prevent similar outcomes to those of SJ?
6. What are the consequences of abortion? Unsafe abortion?
 - a. Physiological, psychological, and social

Unsafe abortion: the preventable pandemic*

David A Grimes, Janie Benson, Susheela Singh, Mariana Romero, Bela Ganatra, Friday E Okonofua, Iqbal H Shah

Ending the silent pandemic of unsafe abortion is an urgent public-health and human-rights imperative. As with other more visible global-health issues, this scourge threatens women throughout the developing world. Every year, about 19–20 million abortions are done by individuals without the requisite skills, or in environments below minimum medical standards, or both. Nearly all unsafe abortions (97%) are in developing countries. An estimated 68 000 women die as a result, and millions more have complications, many permanent. Important causes of death include haemorrhage, infection, and poisoning. Legalisation of abortion on request is a necessary but insufficient step toward improving women's health; in some countries, such as India, where abortion has been legal for decades, access to competent care remains restricted because of other barriers. Access to safe abortion improves women's health, and vice versa, as documented in Romania during the regime of President Nicolae Ceausescu. The availability of modern contraception can reduce but never eliminate the need for abortion. Direct costs of treating abortion complications burden impoverished health care systems, and indirect costs also drain struggling economies. The development of manual vacuum aspiration to empty the uterus, and the use of misoprostol, an oxytocic agent, have improved the care of women. Access to safe, legal abortion is a fundamental right of women, irrespective of where they live. The underlying causes of morbidity and mortality from unsafe abortion today are not blood loss and infection but, rather, apathy and disdain toward women.

Introduction

Unsafe abortion is a persistent, preventable pandemic. WHO defines unsafe abortion as a procedure for terminating an unintended pregnancy either by individuals without the necessary skills or in an environment that does not conform to minimum medical standards, or both.¹ Unsafe abortion mainly endangers women in developing countries where abortion is highly restricted by law and countries where, although legally permitted, safe abortion is not easily accessible. In these settings, women faced with an unintended pregnancy often self-induce abortions or obtain clandestine abortions from medical practitioners,² paramedical workers, or traditional healers.³ By contrast, legal abortion in industrialised nations has emerged as one of the safest procedures in contemporary medical practice, with minimum morbidity and a negligible risk of death.⁴ As with AIDS, the disparity between the health of women

in developed and developing countries is stark. Unsafe abortion remains one of the most neglected sexual and reproductive health problems in the world today. This article will describe the scope of the problem of unsafe abortion, estimate its mortality and morbidity, document the relation between laws and women's health, estimate costs, and describe prevention strategies. The key messages are presented in panel 1.

Worldwide burden

Worldwide estimates for 1995 indicated that about 26 million legal and 20 million illegal abortions took place every year.⁵ Almost all unsafe abortions (97%) are in developing countries, and over half (55%) are in Asia (mostly in south-central Asia; table).⁶ Reliable data for the prevalence of unsafe abortion are generally scarce, especially in countries where access to abortion is legally restricted. Whether legal or illegal, induced

* This is a pre-print copy of a paper published in the journal *The Lancet*: David A Grimes, Janie Benson, Susheela Singh, Mariana Romero, Bela Ganatra, Friday E Okonofua, Iqbal H Shah. Unsafe abortion: the preventable pandemic. The Lancet Sexual and Reproductive Health Series, October 2006.

abortion is usually stigmatised and frequently censured by political, religious, or other leaders. Hence, under-reporting is routine even in countries where abortion is legally available.^{7,8} The use of varying terms, such as induced miscarriage (*fausse couche provoqué*),⁹ menstrual regulation, mini-abortion, and regulation of a delayed or suspended menstruation¹⁰ further compounds the problem of producing reliable and comparable estimates of the prevalence of unsafe abortion.

Community studies around the world indicate a higher magnitude of unsafe abortion than do health statistics.^{3,11,12} In Zambia, the extent of maternal mortality from unsafe abortion is not generally known from health statistics; one study in which women were interviewed revealed that 69% of the respondents knew one or more women who had died from an unsafe illegal abortion.¹² Focus-group discussions and community-based studies in India¹¹ revealed self-reported abortions in 28% of women, which is higher than figures derived from national service-delivery data.

Estimates show that women in South America, eastern Africa, and western Africa are more likely to have an unsafe abortion than are women in other regions. Unsafe abortion rates per 1000 women aged 15–44 years (figure 1) provide a more comparable measure of unsafe abortion by region. In Asia, south-central and southeastern regions have similar unsafe abortion rates (22 and 21 per 1000 women, respectively), whereas the rate is about half (12 per 1000) in western Asia and negligible in eastern Asia (where abortion is legal on request and easily available).

Panel 1: Key messages

1. An estimated 19–20 million unsafe abortions take place every year, 97% of these are in developing countries.
2. Despite its frequency, unsafe abortion remains one of the most neglected global public health challenges.
3. An estimated 68 000 women die every year from unsafe abortion, and millions more are injured, many permanently.
4. Leading causes of death are haemorrhage, infection, and poisoning from substances used to induce abortion.
5. Access to modern contraception can reduce but never eliminate the need for abortion.
6. Legalisation of abortion is a necessary but insufficient step toward eliminating unsafe abortion.
7. When abortion is made legal, safe, and easily accessible, women's health rapidly improves. By contrast, women's health deteriorates when access to safe abortion is made more difficult or illegal.
8. Legal abortion in developed countries is one of the safest procedures in contemporary practice, with case-fatality rates less than one death per 100 000 procedures.
9. Manual vacuum aspiration (a handheld syringe as a suction source) and medical methods of inducing abortion have reduced complications.
10. Treating complications of unsafe abortion overwhelms impoverished health-care services and diverts limited resources from other critical health-care programmes.
11. The underlying causes of this global pandemic are apathy and disdain for women; they suffer and die because they are not valued.

	Number of unsafe abortions (thousands)	Unsafe abortions per 100 livebirths	Unsafe abortions per 1000 women aged 15–44 years
World	19 000	14	14
Developed countries*	500	4	2
Developing countries	18 400	15	16
Africa	4 200	14	24
Asia*	10 500	14	13
Europe	500	7	3
Latin America and the Caribbean	3 700	32	29
Northern America	N/A	N/A	N/A
Oceania*	30	12	17

Source: WHO.6 *Japan, Australia, and New Zealand have been excluded from the regional estimates, but are included in the total for developed countries.
N/A=none or negligible incidence.

Table: Global and regional estimates of annual incidence of unsafe abortion, 2000

Temporal trends in unsafe abortion have been inconsistent internationally (figure 2). Between 1995 and 2000, a decline of 5 or more percentage points took place in the unsafe abortion rate in eastern, middle, and western Africa, the Caribbean, and Central America. Other developing areas had no appreciable change in the rate of unsafe abortion.⁶

Unsafe abortions vary substantially by age across regions: adolescents (15–19 years) account for 25% of all unsafe abortions in Africa, whereas the percentage in Asia, Latin America, and the Caribbean is much lower (figure 3). By contrast, 42% and 33% of all unsafe abortions in Asia and Latin America, respectively, are in women aged 30–44 years, compared with 23% in Africa.¹³ For the developing regions as a whole, unsafe abortions peak in women aged 20–29 years. On the basis of WHO estimates, if current rates prevail throughout women's reproductive lifetimes, women in the developing world will have an average of about one unsafe abortion by age 45 years.¹³

Reasons for seeking abortion are varied: socioeconomic concerns (including poverty, no support from the partner, and disruption of education or employment); family-building preferences (including the need to postpone childbearing or achieve a healthy spacing between births); relationship problems with the husband or partner; risks to maternal or fetal health; and pregnancy resulting from rape or incest.¹⁴ More proximate causes include poor access to contraceptives and contraceptive failure.¹⁴

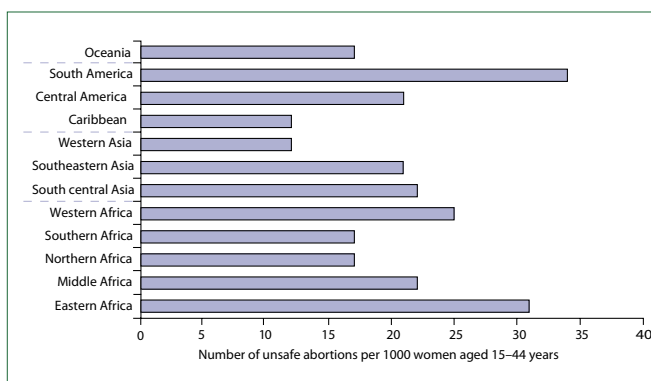


Figure 1: Estimated number of unsafe abortions per 1000 women aged 15–44 years, by subregion

Source: WHO.6 Australia and New Zealand are excluded from estimates of Oceania.

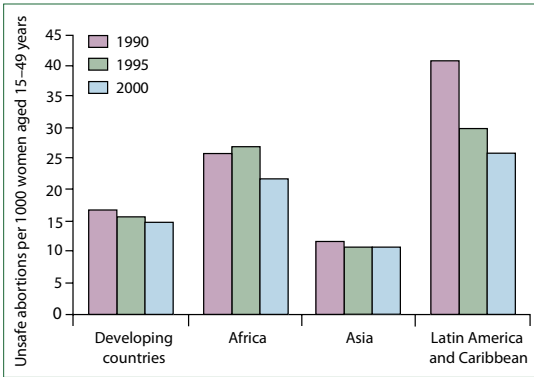


Figure 2: Estimated number of unsafe abortions per 1000 women aged 15–49 years, by region, 1990–2000

Source: Special tabulations using WHO database on unsafe abortion.⁶

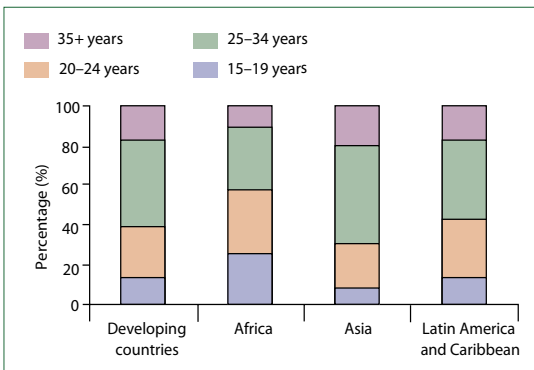


Figure 3: Percentage distribution of unsafe abortions by age group in the developing world and regions

Source: WHO⁶

Deaths from unsafe abortion

Measurement of the worldwide prevalence of abortion-related mortality and morbidity is difficult. At a population level, national vital registration systems routinely under-count such deaths.¹⁵ Calculation of the proportion of maternal deaths due to abortion complications is even more challenging. Abortion-related mortality often happens after a clandestine or illegal procedure, and powerful disincentives discourage reporting. As a result, linking specific programmatic interventions to changes in maternal mortality at a population level is rarely feasible because of the difficulty in accurate measurement of deaths. Moreover, women might not report their condition or might not relate it to a complication of an earlier unsafe abortion.¹⁵

Worldwide, an estimated 68 000 women die as a result of complications from unsafe induced abortions every year—about eight per hour.⁶ This prevalence translates into an estimated case-fatality rate of 367 deaths per 100 000 unsafe abortions, which is hundreds of times higher than that for safe, legal abortion in developed nations. This ratio is higher in Africa (709), lower in Latin America and Caribbean (100), and close to the worldwide average in Asia (324). These differences presumably indicate regional differences in the safety of abortion provision, the severity of complications, and access to care thereafter.⁶ By use of different methods, a recent systematic review of causes of maternal

mortality worldwide estimated that abortion accounted for 1–49% of such deaths.¹⁶ Irrespective of the research methodologies used, the public health message is clear: unsafe abortion kills large numbers of women.

About half of all deaths from unsafe abortion are in Asia, with most of the remainder (44%) in Africa.⁶ The unsafe abortion mortality ratio (the number of unsafe abortion-related deaths per 100 000 livebirths) varies across regions. For the developing world as a whole, this ratio was estimated to be 60 in the year 2000. However, the ratio is much higher in eastern, middle, and western Africa (90–140), and is lower in northern and southern Africa, western and southeastern Asia, and Latin America and the Caribbean (10–40). Unsafe abortion is estimated to account for 13% of all maternal deaths worldwide, but accounts for a higher proportion of maternal deaths in Latin America (17%) and southeastern Asia (19%).

Morbidity from unsafe abortion

Morbidity is a much more common consequence of unsafe abortion than mortality, but is determined by the same risk factors. Complications include haemorrhage, sepsis, peritonitis, and trauma to the cervix, vagina, uterus, and abdominal organs (figure 4). High proportions of women (20–50%) who have unsafe abortions are hospitalised for complications.¹⁷ National studies show that the rate of hospitalisation varies from a low of three per 1000 women per year (in Bangladesh, where menstrual regulation is legally permitted) to a high of 15 in Egypt and Uganda.^{18,19}



Figure 4: Loops of gangrenous small intestine protruding from the vagina after attempted abortion, 20-year-old woman

Source: Oye-Adeniran.¹⁰⁶ Reproduced with permission from *Reprod Health Matters* 2002;10: 18–21.

Morbidity and hospitalisation rates have probably fallen since the early 1990s in response to safer abortion services. In Peru (1989–98) and in the Philippines (1994–2000), the abortion-related hospitalisation rate dropped—by 10% in the Philippines in 6 years and by 33% in Peru in 9 years—though the number of women hospitalised declined much more slowly.²⁰ Increased use of misoprostol (replacing more invasive unsafe methods) probably partly accounts for reduced complications.²¹ In Brazil, the number of women treated in public hospitals for abortion complications dropped by about 28% over 13 years (from 345 000 in 1992 to 250 000 in 2005).²² However, most of this decline took place between 1992 and 1995, and the number has varied little since then. Whereas increased use of misoprostol might have accounted for some of the early decline in abortion-related morbidity, the stability

of the number suggests that most women who have an abortion with misoprostol still seek treatment at public hospitals (Anibal Faundes, personal communication, July 5, 2006).

Severity of complications is another important measure of effects on health. A standardised measure of the severity of complications was used in South Africa before and after legalisation of abortion on request in 1996.²³ The proportion of women classified with severe complications (fever of 38°C or more, organ or system failure, generalised peritonitis, pulse 120 per min or more, shock, evidence of a foreign body, or mechanical injury) in South Africa fell substantially from 16.5% before legalisation to 9.7% after. Applying similar methods, a study in Kenya found that 28% of hospitalised women had severe complications. Gestational age at abortion is a simple predictor of risk: later abortions are associated with increased risks for the woman. Late abortions are common; for example, a third of women treated for abortion complications in public hospitals in Kenya were beyond the first trimester.²⁴ By contrast, spontaneous abortions are uncommon after the first trimester, suggesting that many of these complications stemmed from induced unsafe abortions.

Information on long-term health consequences of unsafe abortion is scarce. The WHO estimates that about 20–30% of unsafe abortions result in reproductive tract infections and that about 20–40% of these result in upper-genital-tract infection and infertility. An estimated 2% of women of reproductive age are infertile as a result of unsafe abortion, and 5% have chronic infections.⁶ Unsafe abortion could also increase the long-term risk of ectopic pregnancy, premature delivery, and spontaneous abortion in subsequent pregnancies. Little is known about women who have complications but who do not seek medical care. Clinicians estimate that the proportion of such women was 14% in Latin America, 19% in south and southeast Asia, and 26% in Nigeria.¹⁸ Similar studies in Guatemala and Uganda yielded estimates of about 20%.^{19,25}

Delays in recognising the need for care and in arranging transportation are common. On reaching a health-care facility, women with complications of unsafe abortion are often met with suspicion or hostility. Their treatment is deferred—sometimes indefinitely.²⁶ This disdain compounds the poor staff training, inoperative equipment, out-of-stock drugs, sporadic supplies of water and electricity, and transportation challenges hampering developing-country health-care facilities.

Life-threatening sepsis or haemorrhage might mean a hysterectomy. Gas gangrene from *Clostridium perfringens* is common with insertion of foreign bodies, and tetanus threatens women who have not been immunised. Women with retained tissue and severe infections might receive only oral tetracycline until they are deemed stable enough for curettage in an operating theatre; many die needlessly during the wait. Delays are especially dangerous when bowel injuries cause peritoneal contamination.²⁷

Traditional methods

Nearly 5000 years ago, the Chinese Emperor Shen Nung described the use of mercury for inducing abortion.²⁸ Although one publication¹⁸ lists over 100 traditional methods used for inducing abortion, unsafe methods today can be divided into several broad classes: oral and injectable medicines, vaginal preparations, intrauterine foreign bodies, and trauma to the abdomen (panel 2). In addition to detergents, solvents, and bleach, women in developing countries still rely on teas and decoctions made from local plant or animal products, including dung. Foreign bodies inserted into the uterus to disrupt the pregnancy often damage the

uterus and internal organs, including bowel. In settings as diverse as the South Pacific and equatorial Africa, abortion by abdominal massage is still used by traditional practitioners. The vigorous pummelling of the woman's lower abdomen is designed to disrupt the pregnancy but sometimes bursts the uterus and kills the woman instead.²⁹

The primitive methods used for unsafe abortion show the desperation of the women. Surveys done in New York City before the legalisation of abortion on request documented the techniques in common use.³⁰ Of 899 women interviewed, 74 reported having attempted to abort one or more pregnancies; 338 noted that one of their friends, relatives, or acquaintances had done so. Of those reported abortion attempts, 80% tried to do the abortion themselves. Nearly 40% of women used a combination of approaches. In general, the more invasive the technique, the more dangerous it was to the woman and the more likely it was to disrupt the pregnancy. Invasive methods, such as insertion of tubes or liquids into the uterus, were more successful than were other approaches. Coat hangers, knitting needles, and slippery elm bark were common methods; the bark would expand when moistened, causing the cervix to open. Another widely used method was to place a flexible rubber catheter into the uterus to stimulate labour.

Surveys suggest that miscellaneous methods and oral medications, such as laundry bleach, turpentine, and massive doses of quinine, were most commonly used in New York.³⁰ Injection of toxic solutions into the uterus with douche bags or turkey basters was common. Absorption of soap solutions into the woman's circulation could cause renal toxicity and death.³¹ Potassium permanganate tablets placed in the vagina were also common; these did not induce abortion but could cause severe chemical burns to the vagina, sometimes eroding through to the bowel.³²

Legal status of abortion

Increasing legal access to abortion is associated with improvement in sexual and reproductive health. Conversely, unsafe abortion and related mortality are both highest in countries with narrow grounds for legal abortion.³³ More than 61% of the world's population resides in countries where induced abortion is allowed without restriction or for a wide range of reasons such as protection of the woman's life, preservation of her physical or mental health, and socioeconomic grounds.³⁴ In 72 countries, most of which are in the developing world, 26% of the world's population lives where abortion is prohibited altogether or allowed only to save the woman's life.³⁴ Most of these restrictive laws originated from European colonial laws from previous centuries, although the European nations discarded their restrictive abortion laws decades ago.

Between 1995 and 2005, 12 countries increased access to legal abortion, including Albania, Benin, Burkina Faso, Cambodia, Chad, Ethiopia, Guinea, Guyana, Mali, Nepal, South Africa, and Switzerland.^{35,36} The strategies used to achieve reform vary by country. Nepal's reforms in 2002, for example, were part of an overall women's rights bill and permit legal abortion with no restriction in the first 12 weeks of pregnancy and afterwards on specific grounds. The previous law allowed no indications for abortion.³⁵ The post-apartheid movement for expanded equality in South Africa led to the 1996 act that allows legal abortion without restriction during the first 12 weeks of pregnancy and afterwards on numerous grounds. Only narrow indications for legal abortion had been previously allowed.³⁵ In early 2006, Colombia's constitutional court ruled in favour of expanded indications for legal abortion, including when a woman's life or health is in danger and in cases of rape or fetal malformation.³⁷

Panel 2: Part inventory of unsafe abortion methods, by route of administration⁹³

Treatments taken by mouth

Toxic solutions

Turpentine
Laundry bleach
Detergent solutions
Acid
Laundry bluing
Cottonseed oil
Arak (a strong liquor)

Teas and herbal remedies

Strong tea
Tea made of livestock manure
Boiled and ground avocado or basil leaves
Wine boiled with raisins and cinnamon
Black beer boiled with soap, oregano, and parsley
Boiled apio (celery plant) water with aspirin
Tea with apio, avocado bark, ginger, etc
“Bitter concoction”
Assorted herbal medications

Drugs

Uterine stimulants, such as misoprostol or oxytocin (used in obstetrics)
Quinine and chloroquine (used for treating malaria)
Oral contraceptive pills (ineffective in causing abortion)

Treatments placed in the vagina or cervix

Potassium permanganate tablets
Herbal preparations
Misoprostol

Intramuscular injections

Two cholera immunisations

Foreign bodies placed into the uterus through the cervix

Stick, sometimes dipped in oil
Lump of sugar
Hard green bean
Root or leaf of plant
Wire
Knitting needle
Rubber catheter
Bougie (large rubber catheter)
Intrauterine contraceptive device
Coat hanger
Ballpoint pen
Chicken bone
Bicycle spoke
Air blown in by a syringe or turkey baster
Sharp curette

Enemas

Soap
Shih tea (wormwood)

Trauma

Abdominal or back massage
Lifting heavy weights
Jumping from top of stairs or roof

Advocacy for increased access to safe legal abortion has increased in countries such as Argentina, Brazil, Indonesia, Jamaica, Kenya, Mexico, Mozambique, Nigeria, Trinidad and Tobago, Uganda, and Uruguay. These efforts are rooted in public health, human rights, and other arguments. Those involved include health and medical professionals, women's groups, legal and human rights advocates, young people, government officials, and, in some countries, trade unionists.³⁸

Several countries have restricted abortion laws in the past decade. El Salvador amended its penal code in 1998 to ban abortion for any legal indication; previous indications had included saving a woman's life, pregnancy resulting from rape, and fetal impairment (panel 3).³⁵ In 1997, Poland's Parliament approved legislation removing social and economic grounds for abortion.³⁵ Anti-abortion voices continue to protest against attempts at legal reform in countries as diverse as Nicaragua, Sri Lanka, and Uruguay. The recent legislation for safer access in Colombia prompted a Roman Catholic cardinal to suggest civil disobedience and to threaten excommunication of judges who voted to support safer laws.³⁹

Panel 3: Prosecution in El Salvador

“After I came out of the coma, they moved me to the maternity hospital. My brother visited and asked me if the police had come to ask me questions. He said the police had come to our house and they had interrogated our relatives and neighbours. They had gone to where I worked. They asked everyone a lot of questions about me and who I was and if they knew whether I was pregnant and whether I'd had an abortion.

When I got home, the prosecutor came to see me, and he asked lots of aggressive questions. He talked to me like I was a criminal. I didn't want to answer because I was scared. He said if I didn't answer, even though I was in bad physical shape, he would put me in jail. He wanted me to tell him who the father of the child was and the name of the person who had done this to me. I didn't know her name. Then he made a date for me to come to the prosecutor's office.”

Anonymous woman in El Salvador⁴⁰

Effect of law on health

The prevalence of unsafe abortions remains the highest in the 82 countries with the most restrictive legislations, up to 23 unsafe abortions per 1000 women aged 15–49 years. By contrast, the 52 countries that allow abortion on request have a median unsafe abortion rate as low as two per 1000 women of reproductive age.³³ Although the case-fatality rate from unsafe abortions indicates the general level of health care and the availability of post-abortion services, the rate remains the highest in countries where abortion is legally restricted. In such countries, the median ratio for unsafe abortion mortality is 34 deaths per 100 000 livebirths; this ratio steadily decreases as legal grounds for abortion increase. The ratio falls to one or less per 100 000 livebirths in countries that allow abortion on request.³³ Even in countries where improved access to health care and emergency obstetric services has greatly reduced overall maternal mortality, restrictive abortion laws translate into abortion deaths constituting a disproportionately high share of maternal deaths (panel 4).⁴¹

Panel 4: Romania and South Africa

Widespread access to legal abortions on request in Romania from 1957 onwards led to a decline in unsafe abortions with an abortion mortality ratio of 20 per 100 000 livebirths in 1960.⁴² Mortality began to rise steadily as Ceausescu's pronatalist restrictive policy imposed in 1966 began to take effect (figure 5). By 1989 mortality ratios had risen seven-fold to peak at 148 deaths per 100 000 livebirths; abortion accounted for 87% of the deaths. When Ceausescu was deposed in 1989, the immediate change of laws reversed this trend. The mortality ratio fell by more than half to 68 within the first year of safer access itself. By 2002, mortality from unsafe abortions was as low as nine per 100 000 livebirths; abortion deaths accounted for less than half of maternal deaths.⁴³

Abortion became legal and available on request in South Africa in 1997.⁴⁴ The Choice on Termination of Pregnancy act No 92 was promulgated in South Africa on Oct 31, 1996, but went into effect on Feb 1, 1997. Since then, the resulting favourable environment has increased women's access to family planning, abortion, and post-abortion care services in the country. After the law was passed, abortion-related deaths dropped 91% from 1994 to 1998–2001.²³

The new law increased women's access to a broad range of options for the prevention and treatment of unwanted pregnancy. In particular, the law led to the increased promotion of family planning, the increased use of manual vacuum aspiration for abortion and post-abortion care, use of manual vacuum aspiration by nurses and midwives, and the introduction of medical abortion methods.

Making abortion legal, safe, and accessible does not appreciably increase demand. Instead, the principal effect is shifting previously clandestine, unsafe procedures to legal and safe ones. Hence, governments need not worry that the costs of making abortion safe will overburden the health-care infrastructure.¹⁸ Countries that liberalised their abortion laws such as Barbados, Canada, South Africa, Tunisia, and Turkey did not have an increase in abortion. By comparison, the Netherlands, which has unrestricted access to free abortion and contraception, has one of the lowest abortion rates in the world.¹⁸

In several countries, legal inquiry, prosecution, and even imprisonment of women who have had an unlawful abortion is not uncommon.⁴⁰ Before the 2002 law change in Nepal, an estimated 20% of the women prisoners nationwide were in jail for charges relating to abortion or

infanticide. Many women who had miscarriage, stillbirths, or induced abortions were jailed on charges of infanticide.⁴⁵

Enabling abortion legislation is necessary but not sufficient: a new law might not translate into widespread access to safe services. India and Zambia both legalised abortion in the early 1970s, but safe, legal abortion remains largely unavailable.⁴⁶ In India, access through the public health system is mainly restricted to cities. Despite a mandate to provide abortion services, in most states fewer than 20% of primary health care centres do so. Many centres only sporadically provide service either because of a shortage of trained physicians or functioning equipment.⁴⁷

Access to safe abortion is also mediated by women's awareness of the law. Knowledge is often poor, even in countries with longstanding liberal laws. Misperceptions about the specifics of the law are not uncommon, thus making women vulnerable to poor care, financial exploitation, and prosecution.^{45,48,49} Even where legal abortion is widely available on request, misperceptions about the legality of minors having sexual intercourse delay some adolescents from seeking care. In many cultures, perceptions of legality are affected by the stigma attached to premarital or extramarital sexual activity. In several south Asian countries, such pregnancies are commonly referred to as illegal or illegitimate, as are the abortions induced in these circumstances.⁵⁰ Misperceptions about legal requirements, such as the need for spousal authorisation and provider attitudes, could create barriers that do not exist in law. These, in turn, might drive unmarried women to unsafe providers (compromising medical safety for confidentiality^{47,51}) or to suicide.⁵²

Costs of unsafe abortion

Treatment of abortion complications burdens public health systems in the developing world. Conversely, ensuring women's access to safe abortion services lowers medical costs for health systems. In some low-income and middle-income countries, up to 50% of hospital budgets for obstetrics and gynaecology are spent treating complications of unsafe abortion.¹⁸ A review of medical records in 569 public hospitals in Egypt during 1 month noted that almost 20% of the 22 656 admissions to obstetrics and gynaecology departments were for treatment of an induced or reportedly spontaneous abortion.⁵³

Direct costs include health personnel, medications, blood, supplies and equipment, and overnight stays. The cost per woman to health systems for treatment of abortion complications in Tanzania is more than seven times the overall Ministry of Health budget per head of population.⁵⁴ Estimates from Uganda comparing costs of treatment of abortion complications with costs of providing safe, elective abortion show the potential resource-savings to health systems. Post-abortion care offered in tertiary hospitals by physician providers was estimated to cost health systems ten times more than elective abortion services offered by mid-level practitioners in primary care (Heidi Johnston, 2004; Ipas, Chapel Hill, NC, USA).

In sub-Saharan Africa, two studies attempted to estimate costs at the national level. A 1997 South African study estimated that the total yearly cost of treating unsafe abortion morbidity in public hospitals was ZAR 9.74 million (about US\$1.4 million).⁵⁵ A 2002 study in Nigeria estimated that the total national cost of direct medical care for treating abortion complication patients was NGN 1400 million (\$11.7 million).⁵⁶ A second study in Nigeria estimated that the national cost of treating unsafe abortion complications in 2005 was \$19 million (Akinrinola Bankole, unpublished data).

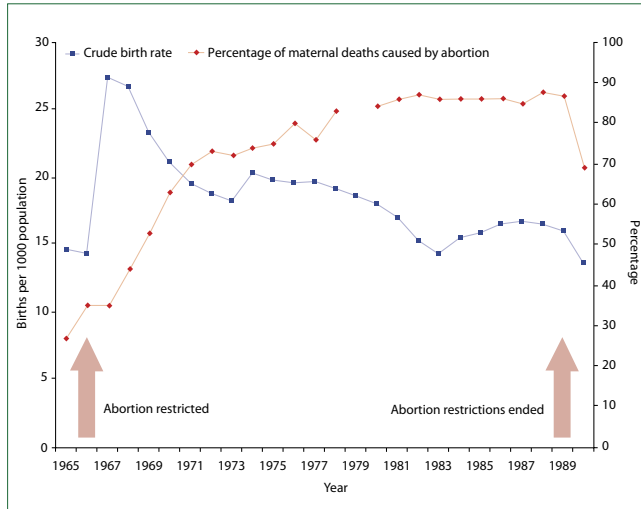


Figure 5: Livebirths and proportion of maternal deaths due to abortion, Romania, 1965–90

Source: David.⁴² Data unavailable for 1979.

Use of manual vacuum aspiration for management of first-trimester incomplete abortions reduces costs. Studies in Bolivia, Mexico, and Peru showed that although the cost per patient for inpatient dilatation and curettage services ranged from \$66–151, a change to ambulatory manual vacuum aspiration reduced costs to \$33–66, a decrease of 56–72%.⁵⁷ Per-patient costs in Kenya fell by 23% in one hospital and 66% in another when post-abortion care services were changed from dilatation and curettage to manual vacuum aspiration in outpatients.⁵⁸ Reductions in overall costs per patient were attributable to shortened hospital stays, less staff time, and fewer medications.

Indirect costs

The indirect costs of unsafe abortion are substantial, yet more difficult to quantify. They include the loss of productivity from abortion-related morbidity and mortality on women and household members; the effect on children's health and education if their mother dies; the diversion of scarce medical resources for treatment of abortion complications; and secondary infertility, stigma, and other sociopsychological consequences. For example, an estimated 220 000 children worldwide lose their mothers every year from abortion-related deaths.⁵⁹ Such children receive less health care and social care than children who have two parents, and are more likely to die.⁶⁰

Estimates of disability adjusted life-years (DALYs) provide an indicator of one part of the indirect costs, women's loss of productive life. An estimated 5 million DALYs are lost per year by women of reproductive age as a result of mortality and morbidity from unsafe abortion.⁶¹ However, this rate probably underestimates the true burden because of limitations in the methods of estimating DALYs resulting from maternal causes.⁵⁹

Stigma impairs health, both directly through harm to wellbeing and indirectly by hindering prompt access to medical care. Stigma related to abortion particularly affects adolescents and unmarried women because of their inexperience and few economic resources.²⁶ Social sanctions against sexual activity are especially problematic for unmarried women.

Levels of prevention

Preventive medicine is traditionally viewed in three levels.⁶² Primary prevention (the domain of public health) protects health by personal and community efforts, such as lowering serum cholesterol and discouraging smoking. Secondary prevention (the domain of preventive medicine) includes early detection and prompt treatment of disease, for example, acute cardiac care for myocardial infarction. Tertiary prevention (rehabilitation) mitigates disability, an example being coronary artery bypass grafting. In general, primary prevention is preferable to secondary and tertiary prevention in terms of both cost and compassion: immunising against poliomyelitis is better than building iron lungs.

Primary prevention includes reduction in the need for unsafe abortion through contraception, legalisation of abortion on request, the use of safer techniques, and improvement of provider skills. Access to safe, effective contraception can substantially reduce—but never eliminate—the need for abortion to regulate fertility. The effect of national contraceptive programmes on reducing the rate of abortion is well documented. In seven countries (Bulgaria, Kazakhstan, Kyrgyzstan, Switzerland, Tunisia, Turkey, and Uzbekistan), abortion rates fell as use of modern contraception rose.⁶³ In another six countries (Cuba, Denmark, Netherlands, Republic of Korea, Singapore, and USA), abortion and contraception increased simultaneously; the uptake of effective contraception did not keep pace with couples' increasing desires for smaller family sizes.

In several of the six countries, abortion rates ultimately declined with continued contraceptive use and stabilisation of fertility rates at lower levels. Even with high rates of contraceptive use, however, unintended pregnancies will continue. No contraceptive method is 100% effective, and many couples in the developing world still encounter obstacles to contraception.⁶⁴ Every year, 80 million women worldwide have an unintended pregnancy, and 60% of these are aborted.¹⁸ Thus, the need for safe abortion will continue.

The developing world has seen a revolution in contraceptive use—from a mere 9% of couples using any method in 1960–65 to 59% in 2003.⁶⁶ Nevertheless, an estimated 27 million unintended pregnancies happen worldwide every year with the typical use of contraceptives. Six million would happen even with perfect (i.e., correct and consistent) use.⁶⁷ An estimated 123 million women have an unmet need for family planning.⁶⁸

All abortion patients—whether seeking treatment of a complication or an elective induced abortion—should be offered contraceptive counselling and a choice of appropriate methods. Results of many studies in Latin America and Africa have shown that after having an abortion patients will accept contraception at high rates.^{57,69–71} Contraceptive counselling and provision at the time of treatment reduced unintended pregnancies and repeat abortions by 50% over 1 year in Zimbabwe, compared with post-abortion patients who did not receive such services.⁷²

The advent of vacuum aspiration in the 1960s revolutionised the primary prevention of complications in developing countries. This technology (figure 6) relies on the use of a simple syringe with a plunger to generate negative pressure for uterine evacuation, and plastic cannulas of varying sizes. The amount of negative pressure obtained with manual vacuum aspiration is similar to that generated with large, expensive, electrical pumps, which makes this method especially suited for use in clinics, offices, and low-resource settings. Manual vacuum aspiration also has

the advantage that the syringe can be cleaned, high-level disinfected, or sterilised and used repeatedly; similarly, cannulas can be discarded or re-used after appropriate disinfection or sterilisation.

Vacuum aspiration is safer than sharp curettage, and the WHO recommends vacuum aspiration as the preferred method for uterine evacuation before 12 weeks of pregnancy.⁶⁷ This method is faster, safer, more comfortable, and associated with shorter hospital stay for induced abortion than sharp curettage.^{73,74} Additional advantages compared with sharp curettage are its ease of use as an outpatient procedure, the need for less analgesia and anaesthesia,⁷⁵ and its lower cost per procedure especially if done on an outpatient basis.⁷⁶ In countries with a small number of physicians, vacuum aspiration can be safely and effectively used by mid-level health service providers, such as midwives.⁷⁷



Figure 6: Manual vacuum aspiration syringe

The combined use of mifepristone and misoprostol has become the standard WHO-recommended medical regimen for early medication abortion,⁶⁷ and is better than either drug alone.⁷⁸ Misoprostol is a prostaglandin E1 analogue marketed for the prevention and treatment of gastric ulcers. However, mifepristone can be expensive and is not available in much of the world, whereas misoprostol is cheap and widely available. Regimens with misoprostol alone as an abortifacient have varied widely, with reported success rates ranging between 87% and 97%.⁷⁹ Increased access to misoprostol has been associated with improved women's health in developing countries, and studies are being done to refine the regimen for misoprostol alone to induce abortion (panel 5).

Secondary prevention entails prompt and appropriate treatment of complications. This includes timely evacuation of the uterus after incomplete abortion. WHO has issued technical and clinical guidelines for the provision of safe abortion care⁶⁷ and treatment of abortion complications.¹ Misoprostol can be used for the management of incomplete abortion,⁸⁶ and vacuum aspiration is better than sharp curettage.^{87,88}

Post-abortion care is spreading worldwide. In Guatemala, with support from the Ministry of Health, the Centro de Investigación Epidemiológica en Salud Sexual y Reproductiva began in 1996 a series of training-of-trainers with teams of nurses and doctors around the country. Content included post-abortion assessment and diagnosis, uterine evacuation procedures and techniques, pain management, infection prevention, management of complications, referral to other sexual and reproductive health services, contraceptive counselling and provision, and follow-up care.⁸⁹

The results of a survey in Addis Ababa showed that almost 30% of maternal deaths in the city resulted from unsafe abortion.⁹⁰ To address the high maternal mortality rate (estimated to be 850 deaths per 100 000 livebirths), the Ministry of Health, Regional Health Bureaus, and several international non-governmental organisations joined forces to improve post-abortion care in the public-health sector. Interventions include clinical training of physicians and midwives, provision of manual vacuum aspiration and other supplies, reorganisation of services, supervisory visits to facilities, and improved record-keeping. Post-abortion care was implemented in 42 health-care facilities in three regions assessed from 2000 to 2004. Quality of care also improved.⁹¹ In 2004, Ethiopia revised its abortion law and in 2006 issued guidelines for safe abortion services.

Critics of post-abortion care worldwide complain that the preoccupation with secondary (rather than primary) prevention of unsafe abortion is myopic, tantamount to placing ambulances at the bottom of a cliff instead of erecting a fence at the top.

Tertiary prevention mitigates long-term damage. Rapid transfer to a hospital can be lifesaving.⁹² Prompt repair of uterine injury could preserve fertility. Acute renal failure and tetanus from unsafe abortions remain important causes of death and lengthy disability.⁹³ Repair of fistulas in bowel and bladder can end the suffering, stigmatisation, and abandonment that these injuries cause.

Panel 5: Misoprostol in South America

After introduction into Brazil in 1986, misoprostol became available over the counter. Soon, women recognised its effectiveness as an abortifacient and began to use the drug for this purpose. Women would self-administer the drug orally and then seek medical assistance if the uterine bleeding did not stop. By 1990, 70% of women treated in hospital for abortion complications in Brazilian hospitals reported having used misoprostol.⁸⁰ The report of a rapid increase in uterine evacuation procedures done in some hospitals as a result of abortions initiated by misoprostol⁸¹ led the Ministry of Health to restrict its sale in 1991. The State of Ceara banned the drug altogether. However, restricting access to the drug did not prevent its use; rather, the drug remained widely available in the black market at inflated prices. Consequently, the rate of abortion complications increased after restriction. Indeed, in Campinas, abortion-related deaths tripled after restricted access to misoprostol.⁸⁰

Women's use of misoprostol in Brazil decreased the severity of unsafe abortion complications, and to some extent also decreased the number of women admitted to hospital. Previously, women would insert foreign bodies into their cervix, which provoked bleeding and led to completion by curettage in hospital. Misoprostol is less likely to cause infection than are foreign bodies.⁸² One hospital recorded a rate of uterine infection of 4% in women who reported using misoprostol, compared with 8% in women who reported having a spontaneous abortion.⁸³

Use of medical abortion has also expanded in Peru.⁸⁴ Although the use of prostaglandins for abortion was infrequent in a 1989 survey, most key informants mentioned it in a similar survey in 1998,⁸⁵ even in remote regions of the country. The wide use of prostaglandins for abortion has been associated with improved health for women. In three other countries, women have widely accepted medical abortion because of its similarity to spontaneous abortion.²¹

The public health imperative

The public health rationale to address unsafe abortion was first drawn to attention by the World Health Assembly four decades ago.⁹⁴ In 1994, the Programme of Action of the International Conference on Population and Development stated, “In circumstances where abortion is not against the law, such abortion should be safe.” The Report of the Fourth World Conference on Women, held in Beijing in 1995, noted “unsafe abortions threaten the lives of a large number of women, representing a grave public health problem as it is primarily the poorest and youngest who take the highest risk”.⁹⁶ At the Special Session of the UN General Assembly in June, 1999, governments agreed that “in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible”.⁹⁷ By investing in abortion safety and availability, governments throughout the world can save the lives of tens of thousands of women every year.^{6,18,98}

Increasingly, private foundations and donor governments, including the UK, Netherlands, Sweden, Norway, Denmark, and Finland, have funded activities to advance access to safe abortion. By contrast, the USA has since 1974 precluded use of development assistance for abortion services. In 2001, the US government re-introduced the even more restrictive Mexico City Policy, known by opponents as the Global Gag Rule. According to this policy, private organisations outside the USA are eligible for family planning assistance only if they agree not to engage in most abortion-related activities, even with their own funds.⁹⁹

International organisations increasingly regard the denial of safe abortion services as a human-rights violation. In 1999, the UN Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW) determined that neglect of health services that only women need is discriminatory and a deficit that governments must remedy. Furthermore, CEDAW noted that criminalisation of abortion is a barrier that states should remove.¹⁰⁰

In 2005, the UN Human Rights Committee ruled against Peru for its denial of a legal abortion; the woman had an anencephalic fetus and was forced to continue the pregnancy to delivery.¹⁰¹ The Inter-American Commission on Human Rights ruled in favour of a 13-year-old Mexican girl's petition; she had been raped and subsequently denied access to a legally permitted abortion by state health and law enforcement officials in Mexico.¹⁰² As a result, the Mexican government will issue guidance for access to abortion for rape victims. Moreover, the government agreed to compensate the young woman and her son for health care, education, and professional development. The 2005 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa is the first international human rights instrument to provide for abortion as a right.¹⁰³

Discussion

Unsafe abortion endangers health in the developing world, and merits the same dispassionate, scientific approach to solutions as do other threats to public health. Although the remedies are available and inexpensive, governments in developing nations often do not have the political will to do what is right and necessary. The beneficiaries of access to safe, legal abortion on request include not only women but also their children, families, and society—for present and future generations.

Women have always had abortions and will always continue to do so, irrespective of prevailing laws, religious proscriptions, or social norms.¹⁰⁴ Although the ethical debate over abortion will continue, the

public-health record is clear and incontrovertible: access to safe, legal abortion on request improves health.⁷³ As noted by Mahmoud Fathalla, “Pregnancy-related deaths ... are often the ultimate tragic outcome of the cumulative denial of women's human rights. Women are not dying because of untreatable diseases. They are dying because societies have yet to make the decision that their lives are worth saving.”¹⁰⁵ Simply put, they die because they do not count.

Conflict of interest statement

DG, a gynaecologist, has done, taught, and studied abortions for 33 years. He has performed abortions as part of his duties as a medical school faculty member and as a private contractor for freestanding abortion clinics. He has served on the Board of Directors of the National Abortion Rights Action League and Planned Parenthood Federation of America.

He is a member of the National Abortion Federation, the American College of Obstetricians and Gynecologists, the American Public Health Organization and other groups that support safe, legal abortion. He is a past chair of the Task Force on Postovulatory Fertility Control of the WHO, which conducts abortion research. He is an editor of a textbook on abortion and a chapter contributor to a gynecology text, both of which have provided modest royalties (less than \$1000 total). He has testified in defence of physicians in medical liability cases concerning abortion. He has testified before Congressional committees twice regarding abortion. He has received honoraria for speaking about abortion at medical meetings. He currently teaches and performs abortions at the University of North Carolina School of Medicine as part of his faculty duties.

He receives a fixed salary from the university, which is not dependent upon the number of abortions he does. JB is an employee of Ipas, a global, non-profit reproductive health organisation focused on safe abortion and women's reproductive rights. Ipas manufactures and distributes manual vacuum aspiration instruments worldwide. SS is employed by the Guttmacher Institute, an organisation committed to improving sexual health and rights, including improving access to safe and legal abortion services. FEO, MR, and BG are members of the steering committee of the International Consortium for Medical Abortion, which aims at expanding access to medical abortion in the context of safe abortion worldwide. BG is a full time salaried employee of Ipas and has never been a provider of abortion services. She has received financial support for and been the principal investigator on several social science studies on maternal health and unsafe abortion. FEO is the Executive Project Director of the International Federation of Obstetricians and Gynecologists and the Honorary Adviser to the President of Nigeria on Maternal and Child Health. He is a member of the Abortion Research Consortium in Africa, and a consultant to several international organisations on abortion matters in Africa. Through the NGO which he founded in 1995, the Women's Health and Action Research Centre, he has received funding specifically from the Lucile and David Packard Foundation to build capacity for safe abortion service delivery among private practitioners in northern Nigeria. He has received very modest honoraria for speaking on abortion in Africa at several international fora. He receives a fixed salary from the university, which is not dependent on his research on abortion. IHS is a social scientist with the Special Programme in Human Reproduction, and coordinator of the Programme's Team on Preventing Unsafe Abortion. His duties include supporting research on social science and operations research in sexual and reproductive health, including users' perspectives on family planning and adolescent and reproductive health. He has given lectures with no financial remuneration from any source besides the fixed salary and associated benefits from WHO. All authors have no financial stake in any abortion clinic, and own no individual stocks in any drug company or medical supply house that might profit from abortion.

Acknowledgments

We thank Elisabeth Åhman, Patty Skuster, and Barbara Crane. I Shah is a staff member of the World Health Organization. The author is responsible for the views expressed in this publication and they do not necessarily represent the decisions, policies, or views of the World Health Organization.

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For more information, please contact:

Department of Reproductive Health and Research
World Health Organization
Avenue Appia 20, CH-1211 Geneva 27
Switzerland
Fax: +41 22 791 4171
E-mail: reproductivehealth@who.int
www.who.int/reproductive-health

Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences

Alison Norris, MD PhD^{a,*}, Danielle Bessett, PhD^b, Julia R. Steinberg, PhD^c,
Megan L. Kavanaugh, DrPH^d, Silvia De Zordo, PhD^e, Davida Becker, PhD^f

Received 23 October 2010; Received in revised form 25 January 2011; Accepted
12 February 2011

doi:10.1016/j.whi.2011.02.010

Abstract available on the [Women's Health Issues](#) website

* Correspondence to: Alison Norris, MD PhD, Department of Population, Family and Reproductive Health, Johns Hopkins Bloomberg School of Public Health, 615 N. Wolfe Street, Room 4035, Baltimore, MD 21205.
E-mail address: anorris@jhsph.edu (A. Norris).

^a Department of Population Family and Reproductive Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland

^b Department of Sociology, University of Cincinnati, Cincinnati, Ohio

^c Department of Psychiatry, University of California, San Francisco, San Francisco, California

^d Guttmacher Institute, New York, New York

^e Goldsmiths College, University of London, Department of Anthropology, New Cross, London, United Kingdom

^f Center for the Study of Women, University of California, Los Angeles, Los Angeles, California

Abstract

Stigmatization is a deeply contextual, dynamic social process; stigma from abortion is the discrediting of individuals as a result of their association with abortion. Abortion stigma is under-researched and under-theorized, and the few existing studies focus only on women who have had abortions. We build on this work, drawing from the social science literature to describe three groups whom we posit are affected by abortion stigma: Women who have had abortions, individuals who work in facilities that provide abortion, and supporters of women who have had abortions, including partners, family, and friends, as well as abortion researchers and advocates. Although these groups are not homogeneous, some common experiences within the groups - and differences between the groups - help to illuminate how people manage abortion stigma and begin to reveal the roots of this stigma itself. We discuss five reasons why abortion is stigmatized, beginning with the rationale identified by Kumar, Hessini, and Mitchell: The violation of female ideals of sexuality and motherhood. We then suggest additional causes of abortion stigma, including attributing personhood to the fetus, legal restrictions, the idea that abortion is dirty or unhealthy, and the use of stigma as a tool for anti-abortion efforts. Although not exhaustive, these causes of abortion stigma illustrate how it is made manifest for affected groups. Understanding abortion stigma will inform strategies to reduce it, which has direct implications for improving access to care and better health for those whom stigma affects.

Introduction

Abortion stigma, an important phenomenon for individuals who have had abortions or are otherwise connected to abortion, is under-researched and under-theorized. The few existing studies focus only on women who have had abortions, which in the United States represents about one third of women by age 45 (Henshaw, 1998). Kumar, Hessini, and Mitchell (2009) recently theorized that women who seek abortions challenge localized cultural norms about the “essential nature” of women. We posit that that stigma may also apply to medical professionals who provide abortions, friends and family who support abortion patients, and perhaps even to prochoice advocates. Does abortion stigma affecting these groups stem from the same root? Do they experience this stigma in the same way? We build on Kumar et al.’s work by exploring how different groups experience abortion stigma and what this tells us about why abortion is stigmatized.

Stigmatization is a deeply contextual, dynamic social process; it is related to the disgrace of an individual through a particular attribute he or she holds in violation of social expectations. Goffman (1963, p. 3) described stigma as “an attribute that is deeply discrediting,” reducing the possessor “from a whole and usual person to a tainted, discounted one.” Many have built on Goffman’s definition over the past 45 years,^a but two components of stigmatization consistently appear across disciplines: The perception of negative characteristics and the global devaluation of the possessor. Kumar et al. (2009) define abortion stigma as “a negative attribute ascribed *to women* who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood” (p. 628, emphasis added). Like Kumar et al. (2009), we dispute any “universality” of abortion stigma. We retain their useful multilevel conceptualization, understanding stigma as created across all levels of human interaction: Between individuals, in communities, in institutions, in law and government structures, and in framing discourses (Kumar et al., 2009).

Abortion stigma is usually considered a “concealable” stigma: It is unknown to others unless disclosed (Quinn & Chaudior, 2009). Secrecy and disclosure of abortion often pertain to women who have had abortions, but may also apply to other groups - including abortion providers, partners of women who have had abortions, and others - who must also manage information about their relationship to abortion. As with women who have had abortions, none are fully in control of whether their status is revealed by - and to - others. Consequently, those stigmatized by abortion cope not only with the stigma once revealed, but also with managing whether or not the stigma will be revealed (Quinn & Chaudior, 2009). Researchers have theorized that concealing abortion is part of a vicious cycle that reinforces the perpetuation of stigma (Kumar et al., 2009; Major & Gramzow, 1999).

We examine how abortion stigma, created across levels of human interaction, is made manifest for different individuals within groups and across groups. Abortion stigma can affect all women. Here, we focus on how different groups - women who have had abortions, abortion providers (e.g., doctors, nurses, counselors, clinic staff), and others who are supporters of women who have had abortions (e.g., husbands, boyfriends, family members, close friends, as well as advocates and researchers) - although not homogeneous, are positioned differently with regard to abortion. Intergroup differences illuminate how people manage abortion stigma and begin to reveal the roots of abortion stigma itself. Understanding abortion stigma will inform strategies to

¹ The growing field of abortion research relies, necessarily, on other fields in which examination and measurement of stigma is more developed.

reduce it, which has direct implications for improving access to care and better health for those stigmatized. We limit our focus here to the United States; a thorough analysis of abortion stigma in other settings is beyond the scope of this paper and deserves attention in its own right.

Groups Affected by Abortion Stigma

Women Who Have Had Abortions

Women in the United States voice complex emotions after abortion, and not all women feel stigmatized by it. Many, however, follow the “implicit rule of secrecy”: Women are expected to keep quiet about abortion (Ellison, 2003). Recent research indicates that two out of three women having abortions anticipate stigma if others were to learn about it; 58% felt they needed to keep their abortion secret from friends and family (Shellenberg, 2010). The experience of stigma varies by individual characteristics, such as religious beliefs, cultural values, and economic status (Kumar et al., 2009). Major and Gramzow (1999) examined effects of individual-level abortion stigma, finding that the more a woman perceived others were looking down on her for having an abortion, the more she felt a need to keep the abortion secret. More than two thirds of women talked about their abortions “only a little bit” or “not at all.” This secret keeping in turn led to more thought suppression regarding the abortion, which hampered postabortion psychological adjustment. That is, the more women experienced stigma, the more likely they were to have adverse emotional outcomes (Major & Gramzow, 1999). Women may believe they will cope poorly with having an abortion because of misinformation they have received about its physical and psychological risks (Major et al., 2009; Russo & Denious, 2005).

Social support that women receive from their immediate social networks, particularly their partners, mitigates the effects of abortion stigma (Kumar et al., 2009). Women who perceive community support for the right to terminate a pregnancy are less likely to feel guilt and shame than those who do not (Kumar et al., 2009). Conversely, stigma surrounding abortion may keep women from seeking or receiving social support. Stigma may also have economic costs for women who feel they must conceal their abortions. Jones, Finer, and Singh (2010) found that, among the 30% of abortion patients covered by private insurance, nearly two thirds paid for abortion care out of pocket, which they attribute in part to stigma. Finally, the persistence of self-induced abortion in the United States may be another indicator of how stigma affects women’s actions (Grossman et al., 2010): Self-induced abortion is one way that women can keep their terminations secret.

The experience of abortion stigma can be transitory or episodic for some abortion patients. Abortion may not become a salient part of their self-concept and may re-emerge only at key moments. For example, a woman who rarely thinks of the abortion she had 20 years ago may find herself face-to-face with abortion stigma when her new father-in-law loudly asserts anti-abortion rhetoric at a holiday dinner or she may re-experience it when she is asked about her reproductive history by her obstetrician. Thus, we caution against reification of individually experienced abortion stigma as something that one always “has” or is always salient.

Women who have had abortions are a heterogeneous group (Jones et al., 2010). Their reasons for terminating their pregnancies also vary (Finer, Frohworth, Dauphinee, Singh, & Moore, 2005). In public discourse and from the perspective of women having abortions, however, the idea that there are “good abortions” and “bad abortions” stemming from “good” and “bad” reasons for having them, is prevalent. Stigma experienced by women who have had

abortions may be mitigated or exacerbated by whether their abortions fall into one category or the other. “Good abortions” are those judged to be more socially acceptable, characterized by one or more of the following: A fetus with major malformations, a pregnancy that occurred despite a reliable method of contraception, a first-time abortion, an abortion in the case of rape or incest, a very young woman, or a contrite woman who is in a monogamous relationship. “Bad abortions,” in contrast, occur at later gestational ages and are had by “selfish” women who have had multiple previous abortions without using contraception (Furedi, 2001). Women who have had abortions may be both the stigmatizer and the stigmatized, believing they had “good abortions” and distancing themselves from others who had “bad abortions” (Rapp, 2000). These moral distinctions may be drawn by any woman having an abortion, whether anti-abortion or prochoice (Arthur, 2000).

Individuals Who Work in Abortion Provision

Most abortions in the United States are provided in freestanding clinics (Jones & Kooistra, 2011). These separate clinics were originally conceived of by women’s movement activists to ensure sensitive, women-controlled care. Today, however, this separateness isolates abortion from mainstream health care and marginalizes both abortion and those who provide it. Although abortion is one of the most common medical procedures among women in the United States (Owings & Kozack, 1998), 87% of U.S. counties lack an abortion provider (Jones & Kooistra, 2011). This inconsistency between supply and demand indicates that a small number of providers supply women with a large proportion of abortion care. In essence, many doctors and staff are channeled by structural forces into becoming “abortion specialists” (Joffe, 1995).

Physicians who are trained to but do not provide abortions describe explicit and subtle practice restrictions and fear of repercussions from colleagues (Freedman, Landy, Darney, & Steinauer, 2010). Consequently, some providers opt to perform abortions only under “extraordinary” circumstances. The climate of harassment and violence at abortion clinics - exacerbated by the murder of abortion provider Dr. George Tiller - also contributes to providers’ experience of stigma (Joffe, 2003; Freedman et al., 2010; Joffe, 2009). Stigma may also depend on the types of abortions physicians perform, with second-trimester abortion more stigmatized than first-trimester abortion (Harris, 2008; Yanow, 2009).

The experience of abortion stigma is different for providers than it is for women who have had abortions. Abortion stigma is close at hand for providers (Harris, 2008). Their work identity is connected to abortion, and exposure to stigmatizing behaviors may be continual. The concentration of the abortion load on a relatively small number of providers suggests that abortion and its associated stigma may be consistently integrated into the identities of abortion clinic doctors and staff.

The consequences of abortion stigma for the well-being of abortion providers have not been well studied, but hypothesized effects include stress, professional difficulties with anti-abortion colleagues, fears about disclosing one’s work in social settings, and burnout. Some efforts are currently underway to help abortion providers cope with the stresses and stigma of their work (Harris, 2008). Providers counter the negative effects of abortion stigma with positive beliefs that their work is valuable and that it contributes to patients’ well-being in a profound way. Many abortion providers actively support each other.

Supporters of Women Who Have Had Abortions

Supporters of women who have had abortions, including partners, family, and friends, as well as abortion researchers and advocates, may experience a “courtesy stigma” that arises from being associated with women who have had abortions or with providers (Goffman, 1963). Research about male partners of women obtaining abortions has found that they often experience complex emotions similar to those reported by women: Ambivalence, guilt, sadness, anxiety, and powerlessness (Shostak, Koppel, & Perkins, 2006), yet whether they also experience stigma has yet to be studied. Research is needed to understand whether abortion stigma affects male partners and other family members.

Information about stigma experienced by prochoice advocates and researchers who study abortion is also limited. Based on our own experiences, we believe that researchers may experience difficulty securing funding for studies on abortion or may encounter pressure to study “less controversial” topics. We would be interested to see an investigation of how this stigma influences scholars’ research funding, publication patterns, and overall career paths.

Why Is Abortion Stigmatized?

Abortion Is Stigmatized Because It Violates “Feminine Ideals” of Womanhood

As Kumar et al. (2009) deftly demonstrate, abortion violates two fundamental ideals of womanhood: Nurturing motherhood and sexual purity. The desire to be a mother is central to being a “good woman” (Russo, 1976), and notions that women should have sex only if they intend to procreate reinforce the idea that sex for pleasure is illicit for women (although it is acceptable for men). Abortion, therefore, is stigmatized because it is evidence that a woman has had “nonprocreative” sex and is seeking to exert control over her own reproduction and sexuality, both of which threaten existing gender norms (Kumar et al., 2009).

The stigmatization women experience may not be rooted in the act of aborting a fetus; stigma may instead be associated with having conceived an unwanted pregnancy, of which abortion is a marker. Stigma may be associated with feelings of shame about sexual practices, failure to contracept effectively, or misplaced faith in a partner who disappoints. Abortion can be seen here as one of several “bad choices” about sex, contraception, or partner (Furedi, 2001).

Abortion Is Stigmatized by Attributing Personhood to the Fetus

Technological changes during the past three decades – fetal photography, ultrasound, advances in care for preterm infants, fetal surgery - have facilitated personification of the fetus and challenged previous constructions of boundaries between fetus and infant. Prochoice groups have debated appropriate gestational age limits (Furedi, 2010). Anti-abortion forces have helped to shape this debate by using fetal images (many of which were not alive or in utero as implied by the photos) and interpreting them in ways that suggest abortion is equivalent to murder (Morgan & Michaels, 1999). These images have effectively erased pregnant women from view, decontextualizing the fetus and overstating its independence from the woman who carries it and the social circumstances of her life (Taylor, 2008). Abortion stigma is affected both by legislative initiatives that establish fetal personhood and gestational age limits and by discourses that influence cultural values. By constructing the fetus as a person and abortion as murder, anti-abortion forces argue that women or providers - or both - should be seen as murderers.

Abortion stigma via personification of the fetus affects individuals differently. Women who have had abortions may find ready justifications for a one-time action. Providers, in contrast, have to cope with an ongoing relationship to abortion, sometimes as they themselves become pregnant or parents (Harris, 2008).

Abortion Is Stigmatized Because of Legal Restrictions

We see an important intertwining of law, morality, and stigma. Legal restrictions (e.g., parental consent requirements, gestational limits, waiting periods, and mandated ultrasound viewing) in the United States make it more difficult for women to obtain abortions and reinforce the notion that abortion is morally wrong. Stigma is a barrier to changing abortion law. This is of particular concern because severe legal restrictions are correlated with unsafe abortion, which contributes to morbidity and mortality (Singh, Wulf, Hussain, Bankole, & Sedgh, 2009).

Changes in the legal situation do not necessarily diminish stigma in social discourse. The stigma of abortion did not go away when it was legalized in the United States. In fact, lowering the legal barriers revealed an enduring cultural stigma (Joffe, 1995).

Abortion Is Stigmatized Because It Is Viewed as Dirty or Unhealthy

The legacy of “back alley” abortionists has left a perception in the United States that abortion is dirty, illicit, and harmful to women. Unfortunately, abortion is still marred by unsafe practices in some places, usually where it is illegal. Occasionally abortion is unsafe in places where, although legal, stigma flourishes, including some instances in the United States. Drawing on this deep historical stigma, anti-abortionists in the United States have championed a new argument that “abortion hurts women.” This argument, which positions women as victims of a profiteering abortion machine and the ostensible objects of pity, reduces providers to cruel and callous manipulators and women to “damaged goods.” Unsubstantiated links between abortion, breast cancer, and impaired fertility have been used to frame a “women-centered” anti-abortion strategy (Littman, Zarcadoolas, & Jacobs, 2009; Siegel, 2008). In contrast with other examples, in which abortion reveals or symbolizes flaws in women’s character, here women become flawed because of the experience of having an abortion, and the abortion provider is further tainted, now harming both fetus and woman.

Seven states have integrated groundless claims about the psychological effects of abortion (such as so-called post-abortion syndrome) into regulations. These institutional practices deny the normalcy of abortion as technique and as medical care and reinforce stigmatizing ideas that abortion is unhealthy.

The clinic, itself a stigmatized place, can reinforce stigma for women: Set off from other medical practices and beset by picketers, the institutional arrangements of abortion provision may validate abortion stigma. Abortion providers themselves are not always free of stigmatizing attitudes, and women may internalize abortion stigma so deeply that they feel judged even by those who support their decisions. Abortion stigma may cause women to feel less empowered to ask questions about the procedure and its health consequences. Research is needed to understand whether women are less likely to challenge poor treatment, or to tell others if they receive low-quality care, or if they feel that they “got what they deserved” if treated disrespectfully. When male partners accompany women to abortion visits, they are generally not allowed to stay with their partners during the procedure and rarely receive information or counseling from the staff

(Shostak et al., 2006). The experience of being in the clinic does not have to be stigmatizing; however, it can be a powerful source of comfort and destigmatization for women having abortions, their supporters, and the individuals who work there (Littman et al., 2009). Women's experiences at the clinic may be strongly influenced by their expectations as well as by what happens there, and research is needed to clarify the role of the clinic in abortion stigma.

Abortion Is Stigmatized Because Anti-Abortion Forces Have Found Stigma a Powerful Tool

The anti-abortion movement increasingly seeks both to erect overt barriers to abortion and to change cultural values, beliefs, and norms about abortion so that women will seek abortion less frequently regardless of its legal status. From photographing women entering clinics to distributing flyers to the neighbors of providers, the anti-abortion movement fomented abortion stigma as a deliberate tactic, not just as a byproduct of its legislative initiatives. Eroding public support for the idea of abortion is seen as an underpinning of future institutional limits (Joffe, 2009).

Conclusion

One pernicious effect of abortion stigma may be that physicians are unable to receive training in abortion procedures, decline to be trained, or, if trained, face barriers to providing abortions. Future studies should investigate whether abortion stigma leads some physicians to refuse to provide legal abortions. Conscientious objection on religious grounds, by challenging the morality of abortion, may lead both to lack of training opportunities and to trainees refusing to be trained, further enhancing abortion stigma. Another concern warranting study is that abortion stigma may cause some women to carry their pregnancies to term, to assume a disproportionate economic burden for care, or to seek abortion care clandestinely. It may be that the most vulnerable groups of women are unable to get abortions because of this social barrier. We propose the following recommendations to counter abortion stigma.

Normalize Abortion Within Public Discourse

Silence is an important mechanism for individuals coping with abortion stigma; people hope that if no one knows about their relationship to abortion, they cannot be stigmatized. Nevertheless, even a concealed stigma may lead to an internal experience of stigma and health consequences (Quinn & Chaudior, 2009). We recognize the importance of advocacy and programs that aim to normalize abortion and allow people to speak, such as Baumgardner's "I had an abortion" T-shirt campaign and Exhale's "pro-voice" services, among others. Abortion providers, like women who have had abortions and those who support them, may need targeted supports and outlets. We should engage popular media, including popular entertainment, in the effort to remind people that abortion is common and usual. We need to continue to work with policy makers so that health care and other reforms do not further marginalize and stigmatize abortion services (Weitz, 2010). Empirical research would help to assess the effectiveness of these initiatives and their potential for decreasing abortion stigma. We see a need for work comparing abortion with other social phenomena that have become less stigmatized, such as cancer and homosexuality, to understand better the processes of destigmatization.

Be Aware of Language Used Within Community of Abortion Supporters

The prochoice community, researchers, and advocates need to avoid language that endorses “good” versus “bad” reasons for abortions. Prochoice people should not distance themselves from abortion, invoking “safe, legal, and rare” language, which perpetuates the stigma (Weitz, 2010). Considering the controversies, political advocacy, and social discourse around abortion may illuminate the ways in which particular conflicts have increased or reduced abortion stigma.

Maintain and Strengthen Training Initiatives

The growing movement to make abortion training more research based has helped to improve its standing and to integrate abortion care within academic medicine. The Family Planning Fellowship provides advanced abortion training to board-certified obstetrician/gynecologists and family medicine physicians in 21 universities across the United States. The Society of Family Planning and the National Abortion Federation support ongoing training and research by providing cutting-edge curricula and institutional support for clinical researchers and providers. Physicians for Reproductive Choice and Health has created prizes for abortion providers at the American College of Obstetrics and Gynecology and the New York Academy of Medicine specifically to counter stigma and push medicine to claim abortion as a legitimate procedure. As social scientists who have benefitted tremendously from the Charlotte Ellertson Social Science Postdoctoral Fellowship in Abortion and Reproductive Health, we advocate for the resumption of this program, which filled an important gap in training.

Conduct Research Into Experiences of Stigma Within and Among Groups

Measuring abortion stigma is not easy. We eagerly anticipate new work from Kumar on program design and evaluation for measuring abortion stigma as well as a validated stigma scale for women having abortions being developed by Cockrill and others at Advancing New Standards in Reproductive Health, a program of the University of California at San Francisco’s Bixby Center for Global Reproductive Health. We look forward as well to the contributions of Harris and colleagues about the stigma of abortion work. We acknowledge the concern of some prochoice advocates that a renewed focus on abortion stigma may inadvertently heighten that stigma. We argue, however, that abortion stigma is worthy of attention specifically because the evidence is so limited. Refining our understanding of how stigma operates within and between groups and why abortion is stigmatized will benefit not only the groups identified, but also society in general.

Acknowledgments

An earlier version of this paper was presented at the Social Science Networking Meeting at the National Abortion Federation meeting in April 2010. We are grateful for the many helpful comments we received at that time from participants and panelists, as well as the suggestions of two anonymous reviewers. We also gratefully acknowledge the funding and support of the Charlotte Ellertson Social Science Postdoctoral Fellowship in Abortion and Reproductive Health.

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Author Descriptions

The six authors were Ellertson Fellows from 2008-2010.

Alison Norris, MD, PhD, is a Postdoctoral Fellow the Johns Hopkins Bloomberg School of Public Health in Baltimore, MD. She pursues multi-method research on sexual and reproductive health in under-served women and men.

Danielle Bessett, PhD, is an Assistant Professor of Sociology at the University of Cincinnati, Cincinnati, OH. Her research interests are in medical and family sociology, focusing on sexual and reproductive health issues and inequality.

Julia R. Steinberg, PhD, is an Assistant Professor of Health Psychology in the Department of Psychiatry at UCSF. Her research interests are at the intersection of psychology and reproductive health.

Megan L. Kavanaugh, DrPH, is a Senior Research Associate at the Guttmacher Institute, New York, NY. Her research portfolio has focused on unintended pregnancy, contraceptive use, post-abortion contraception and attitudes about abortion.

Silvia De Zordo, PhD, is a Visiting Researcher at Goldsmiths College-University of London. Her research interests are in social and medical anthropology, focusing on sexual and reproductive health issues and inequality.

Davida Becker, PhD, is a Research Scholar at the Center for the Study of Women at the University of California, Los Angeles. Her research focuses on the accessibility and quality of reproductive health services and disparities in reproductive health outcomes.

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RU-486 abortion pill approved by Health Canada

Doctor's prescription will be required to purchase drug

CBC News Posted: Jul 30, 2015 6:02 AM ET | Last Updated: Jul 30, 2015 9:21 PM ET



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The abortion drug known as RU-486 has received the green light from Health Canada.

The regulator said late Wednesday it has approved the use of **Mifegymiso** to terminate pregnancies up to a gestational age of 49 days.

Canadian women will need to obtain a prescription from a doctor to purchase the combination drug.

- **RU-486: What you need to know**
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"Health Canada confirms that this decision has been taken and that the company has been informed yesterday," a spokesman said in an email.

The product will be distributed by Celopharma Inc. and is expected to be available for sale in winter 2016, said a statement from the drug's manufacturer, London, U.K.-based Linepharma International Limited.

"The decision does not rest with me," Health Minister Rona Ambrose said Thursday from St. Albert, north of Edmonton. "It's out my hands and the decision is final."

The drug has been available since 1988 in France. The drug was approved for use in the United States in 2000 and is also available in more than 57 countries, Linepharma said.

While it is often called mifepristone, mifegymiso contains two

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■ Health Canada approval of Mifegymiso

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drugs, mifepristone and misoprostol. The former blocks production of the hormone progesterone, needed to sustain a pregnancy. The latter prompts the uterus to contract and expel the placenta and the fetus.

Canadian women will take one pill at a doctor's office, go home and take four pills within 12 to 24 hours and then return to the doctor one to two weeks later for a followup visit, a spokeswoman for Linepharma said.

Vicki Saporta, president and CEO of the National Abortion Federation and its Canadian offshoot, NAF Canada, said the application has been before Health Canada since December 2012.

Gold standard approach

"No one can claim that they fast-tracked the approval process and didn't very thoroughly and completely review the application," Saporta said.

NAF Canada represents health-care professionals who provide most of the abortion care in this country and worked to introduce the drug in Canada.

Dr. Erika Feuerstein, a family physician at Women's College Hospital and Bay Centre for Birth Control in Toronto, said it's more effective and efficient than the current medical option available in Canada — a combination of anticancer injectable drug methotrexate followed by misoprostol.

"It works a bit faster, it has a higher success rate," Feuerstein said.

Some women want to have a surgical abortion and other women prefer a medical abortion, Feuerstein said. "It's nice that they can have the option to choose which method serves them the best."

Surgical abortion will continue to be important in situations when the medical abortion fails, Feuerstein added.

Studies suggest the drug can be used safely as late as 70 days into a pregnancy.

Dr. André Ulmann, lead scientist on RU-486 at Linepharma, said the company always starts with 49 days when seeking market authorization to be cautious.

Health Canada did not answer questions from CBC News on details of the approval.

Dr. Jennifer Blake, CEO of the Society of Obstetricians and Gynecologists in Ottawa, said both OBGYNs and family physicians who complete training on the safe use of this medication will be able to prescribe it.

Asked about the timing of the decision, Blake said the society was notified in the winter about the status of the decision and it was released on schedule.

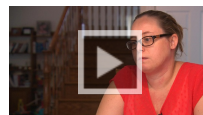
Rebecca Cook, a law professor in the International Reproductive and Sexual Health Law Program at the University of Toronto, wrote a 2013 commentary in the Canadian Medical Association Journal that was titled **"Medical abortion in Canada: behind the times."**

"The approval of the mifepristone/misoprostol product by Health Canada is an important achievement for Canada. Science has prevailed over ideology to ensure that women have access to the benefits of scientific progress," Cook said in a statement to CBC News.

Mifepristone with misoprostol is considered the "gold standard" for medical abortions, Cook and her co-author Dr. Sheila Dunn of Women's College Hospital in Toronto said in their commentary. It's included in the World Health Organizations list of **"essential medicines"** — the minimum medicines needed for basic health-care systems, based on



After a review lasting longer than two years, Health Canada has approved the abortion-inducing drug RU-486, bottles of which are shown in this his September 2010 photo. (Charlie Neibergall/Associated Press)



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Pointe-Claire clinic changes policy after mother told doctor not comfortable treating children. Mother told she had to come back to clinic later



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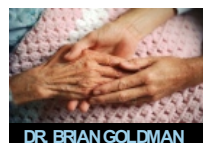
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DR. BRIAN GOLDMAN

criteria such as safety and cost effectiveness.

University of Toronto ethicist Kerry Bowman expects that will increase access to abortion for women who live in rural and remote places.

"The hope is that with time it will enter into further out there areas. Maybe even midwives, even nurse clinicians. I don't know. I'm not saying that now, but over time."

With files from The Canadian Press and CBC's Marisa Dragani



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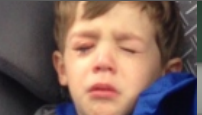



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Regulatory decision summary: MIFEGYMISO

Active ingredient(s)

mifepristone, misoprostol

Therapeutic area

Progesterone Receptor Modulators

What was the purpose of this submission?

A New Drug Submission was filed to seek market authorization for Mifegymiso, a combination drug product of mifepristone and misoprostol, to be used sequentially for the termination of a developing intra-uterine pregnancy up to a gestational age of 49 days.

Why was the decision issued?

The decision to authorize Mifegymiso for the Canadian market was made further to a thorough review of the data package provided by the sponsor that supported the safety, efficacy and quality of the product. The sponsor provided clinical, non-clinical and quality evidence in the form of study data, literature as well as post-approval experience in other countries. It also included proposed risk management measures designed to mitigate the risks known to be associated with this product. During the review process, requests for additional information and clarifications were satisfactorily addressed by the sponsor. Product labelling was revised in order to reflect and communicate the benefits, risks and uncertainties identified in the submission review. Therefore, based on the information in the submission and on the labelling and risk management measures proposed by the sponsor, it was concluded that the evidence provided supports the use of Mifegymiso for the medical termination of a developing intrauterine pregnancy with a gestational age up to 49 days as measured from the first day of the Last Menstrual Period based on a standard 28-day cycle.

The pharmacology evidence provided indicates that Mifegymiso acts to block progesterone effects on the endometrium and myometrium, allows cervical dilatation, and induces contractions of the uterine myometrium that leads to pregnancy termination.

The clinical data to support the authorized indication and dosing regimen were presented in three pivotal clinical trials involving a total of 934 women with a pregnancy with a gestational age of 49 days or less. These data demonstrated that 200 mg oral mifepristone followed by buccal administration of 800 mcg misoprostol 24 to 48 hours later effectively induced the termination of pregnancy in 95.2% to 98.0% of women.

Analysis of the pivotal trials revealed that the average bleeding time was 10.8 days including 2 days of heavy bleeding. The majority of adverse events reported were transient and mild to moderate in severity. The medication causes vaginal bleeding and commonly induced pain and cramping, which required pain medication in some women. The other adverse events more commonly reported were diarrhea, nausea, vomiting, fever/chills, headache, dizziness and weakness. Treatment failure (which was defined as viable pregnancy, non-viable persistent pregnancy, persistent bleeding and abdominal pain that required a surgical termination of pregnancy) was reported in 2% to 4.8% of women.

A small number of patients who took Mifegymiso presented more serious complications, such as pelvic infections (endometritis, salpingitis) and vaginal haemorrhages. Rare cases of fatalities were reported, therefore access to emergency care which can provide gynaecological surgical procedures, antibiotic intravenous therapy and blood transfusion in the rare cases where complications occur, is recommended in the labelling to ensure patient's safety.

The data provided to support this indication included data for women less than 18 years of age. The efficacy of Mifegymiso in these patients was similar to that seen in adults, however nausea and pain were reported more frequently in these patients. There were insufficient data to comment on the safety and efficacy in patients less than 15 years of age.

The mifepristone formulation proposed for the Canadian market was tested in one trial and was shown bioequivalent to the formulation used in the two other trials. Bridging of misoprostol was considered sufficiently robust for regulatory approval based on chemistry, clinical and regulatory criteria. In addition, efficacy and safety of the proposed mifepristone and misoprostol combination were further supported in 5356 patients that have used Mifegymiso (200 mg oral mifepristone and 800 mcg buccal misoprostol) for the indication of medical termination of pregnancy as reported in an additional post market

study.

To support the safe and effective use of Mifegymiso, Linepharma International Ltd. agreed to implement risk management activities including physician only dispensing, development of an education and registration program for prescribers and a post-approval observational safety study. Additional risk management measures include a 24 hour patient support line, a patient consent form and distribution of Patient Medication Information to be provided to each patient.

Decision issued

Approved; issued Notice of Compliance in accordance with the [Food and Drug Regulations](#).

Date of decision

2015-07-29

Additional information

Manufacturer

Linepharma International Limited

Drug Identification Numbers (DIN) issued

DIN 02444038

Prescription status

Mifegymiso is available by prescription only.

Type of submission

New Drug Submission (New Active Substance)

Date filed

2012-11-14

Control number

160063





Contact

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