Reasons for the use of of medical versus surgical abortion in Europe

Alberto Stolzenburg Ramos

FIAPAC Conference Lisbon 14-15 october 2016

Data sources

Questionnaire about abortion practice in Europe: Medical versus Surgical Method

1. Up to how many weeks are abortions performed in your country for each method ?
2. Where are abortions performed (hospital, outpatient clinic, private practice etc.)?
3. Does the administration demand different requirements for both methods ?
4. What is the proportion of medical vs. surgical abortions in your country ?
5. Do you think that women have free choice to decide about both methods ?
6. If not, why not ?
7. Are official statistics on abortion ? (if yes, what links ?)

Questionnaire sent to 43 experts from 33 countries:
22 Fiapac Board members of 16 countries
21 others from 16 countries

→ **27 answers from 27 countries**

National statistics and bibliography (INED, DSG, DESTATIS ,MSSSI, HCEfh etc.)

ABORTION METHODS AND TECHNIQUES

Surgical Abortion

Vacuum Aspiration + anesthesia (local / general / sedation)

D & C + anesthesia (local / general / sedation)

D & E + anesthesia (local or general or sedation)

D & E + vacuum + anesthesia (local / general / sedation)

D & E + vacuum + anesthesia + Misoprostol

D & E + vacuum + anesthesia + Misoprostol + Mifepristone

Medical Induction + surgical termination + anesthesia

Medical Abortion

Misoprostol + analgesics

Misoprostol + Mifepristone + analgesics

Main reasons for the use of medical vs. surgical method in Europe

legislation + administrative regulations

Mifepristone not available

Misoprostol not approved and off-label use

private or public provider

type of facility: doctor's office outpatient clinic hospital

who performs the abortions ?
GP's Ob/Gyn's
Nurses Midwifes

no training in SRH for students and postgraduates

lack of professionals

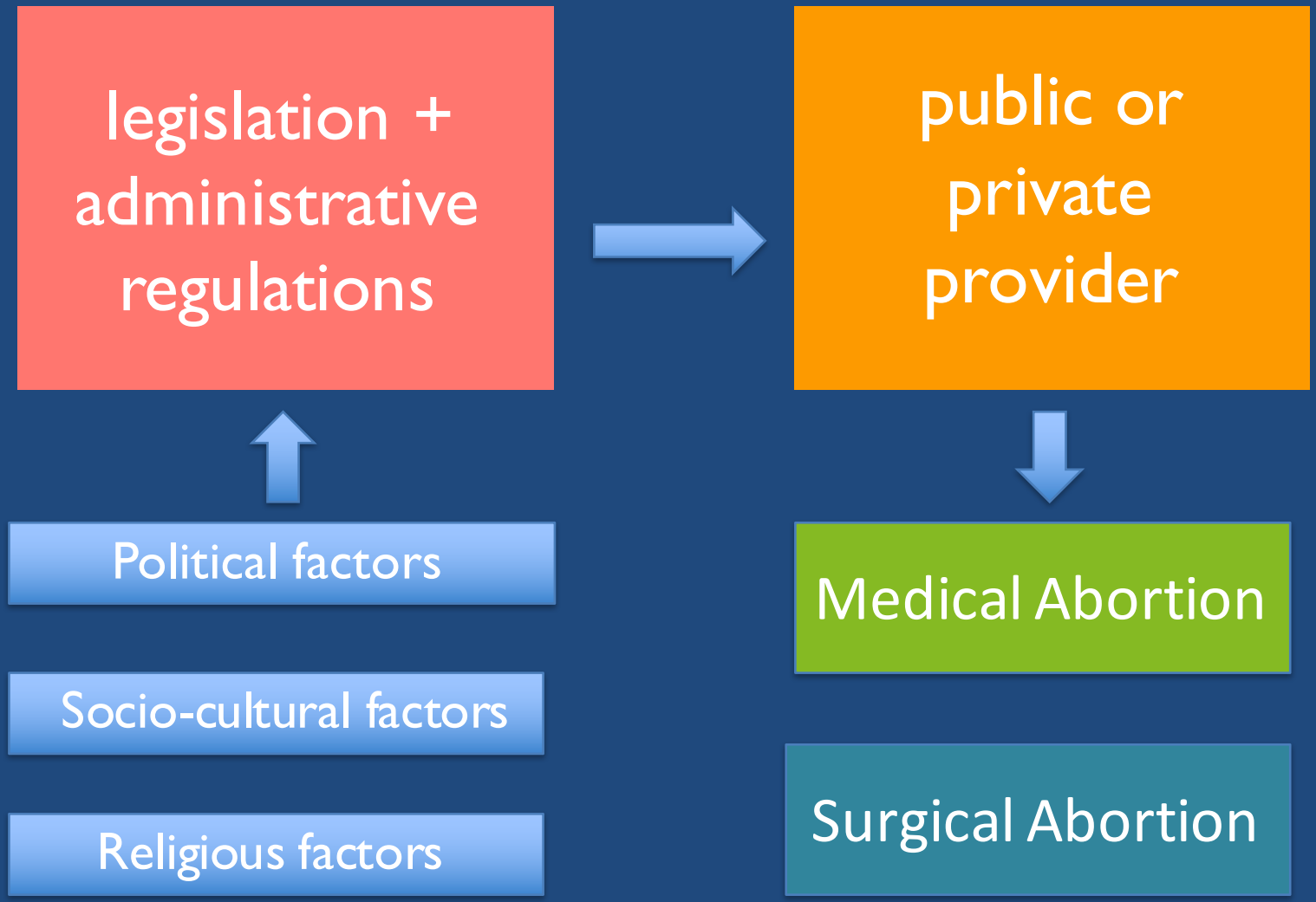
Tradition: preference for one method by doctors and women

economic reasons

who pays the abortions ?

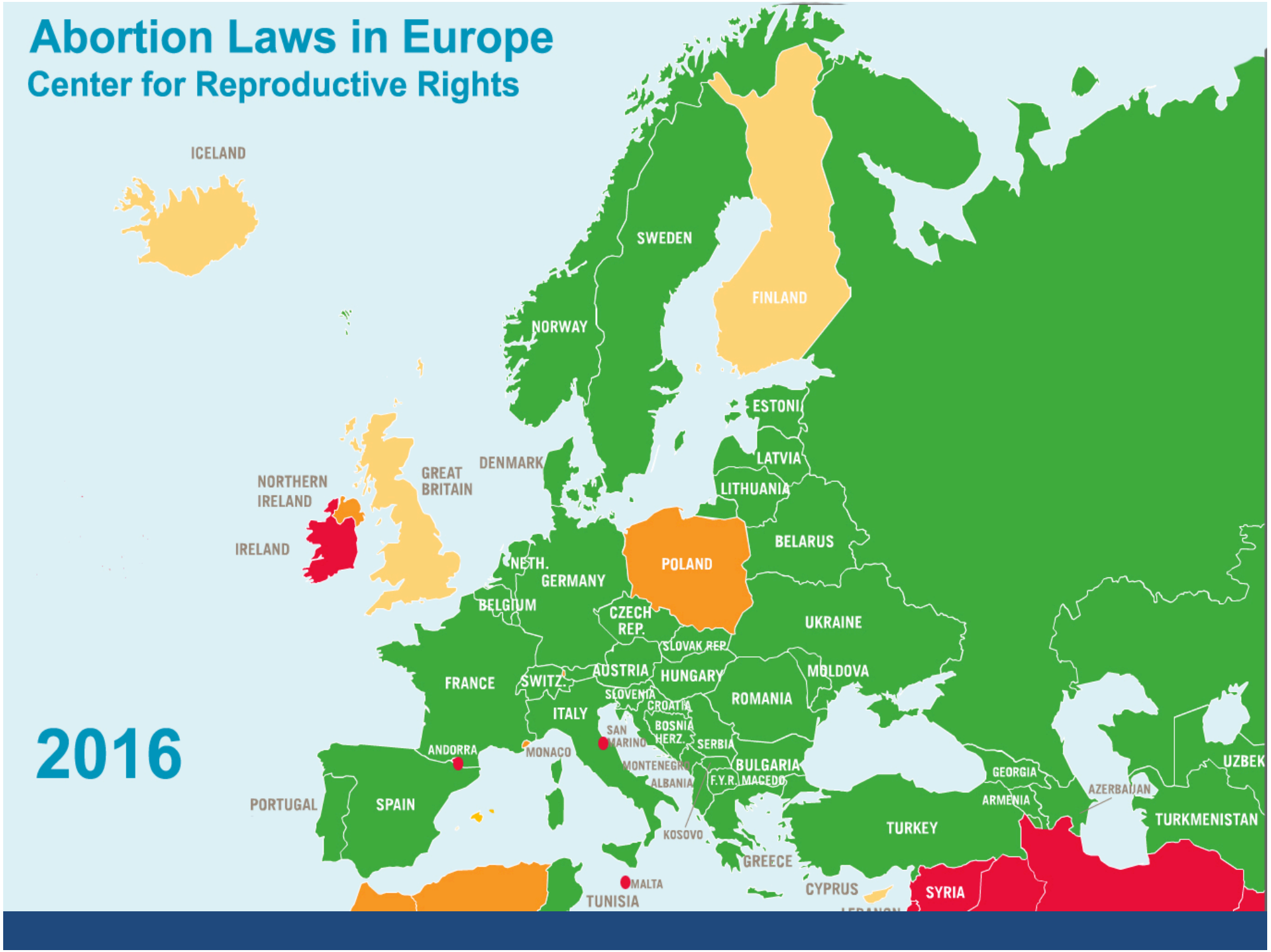
Is women's choice guaranteed ?

Main reasons for the use of medical vs. surgical method in Europe



Abortion Laws in Europe

Center for Reproductive Rights



2016

Abortion laws in Europe : on request time limits

- 10 weeks	Portugal Turkey Serbia Macedonia Bosnia-H.
- 11 weeks	Estonia
- 12 weeks	Germany France Austria Belgium Denmark Finland Switz. Greece Slovakia Czech Rep. Lithuania Latvia Hungary Norway Russia Ukraine Bulgaria Albania Moldova
- 13 weeks	Netherlands
- 14 weeks	Spain, Romania
- 16 weeks	Island
- 18 weeks	Sweden
- 24 weeks	England/ Wales Scotland

Up to how many weeks are medical abortions performed in Europe ?

5 weeks gestation	7 weeks	9 weeks	10 weeks	12 weeks	20-24 weeks	not available
France + Luxemb. private office	**France + Luxemb.** Hospital **Spain Belarus Ukraine Italy Moldova Latvia Switzerl.**	**Germany Spain Holland Austria**	**Portugal**	**Bulgaria Romania Latvia** private office **Greece**	**Sweden Norway Finland England/ Wales Scotland Russia Moldova**	**Ireland Turkey Poland**

Up to how many weeks are surgical abortions performed in Europe ?

10 weeks	12 weeks	14 weeks	22 weeks	24 weeks
Portugal Turkey	France Germany Belarus Finland Ukraine Moldova Sweden Bulgaria Luxembourg Italy Romania Switzerland Russia Norway Greece	Austria Spain	Spain Netherlands	England/Wales Scotland

Does the administrations demand different requirements for surgical or medical abortion ?

yes	no	not applicable
France	Switzerland	Ireland
England/Wales	Romania	Poland
Russia	Netherlands	Turkey
Italy	Bulgaria	
Luxembourg	Finland	
Belarus	Portugal	
Moldova	Germany	
Austria	Spain	
Belgium	Greece	
Sweden		
Latvia		
Norway		
Ukraine		
Spain(Catalonia,Balearics)		
Scotland		

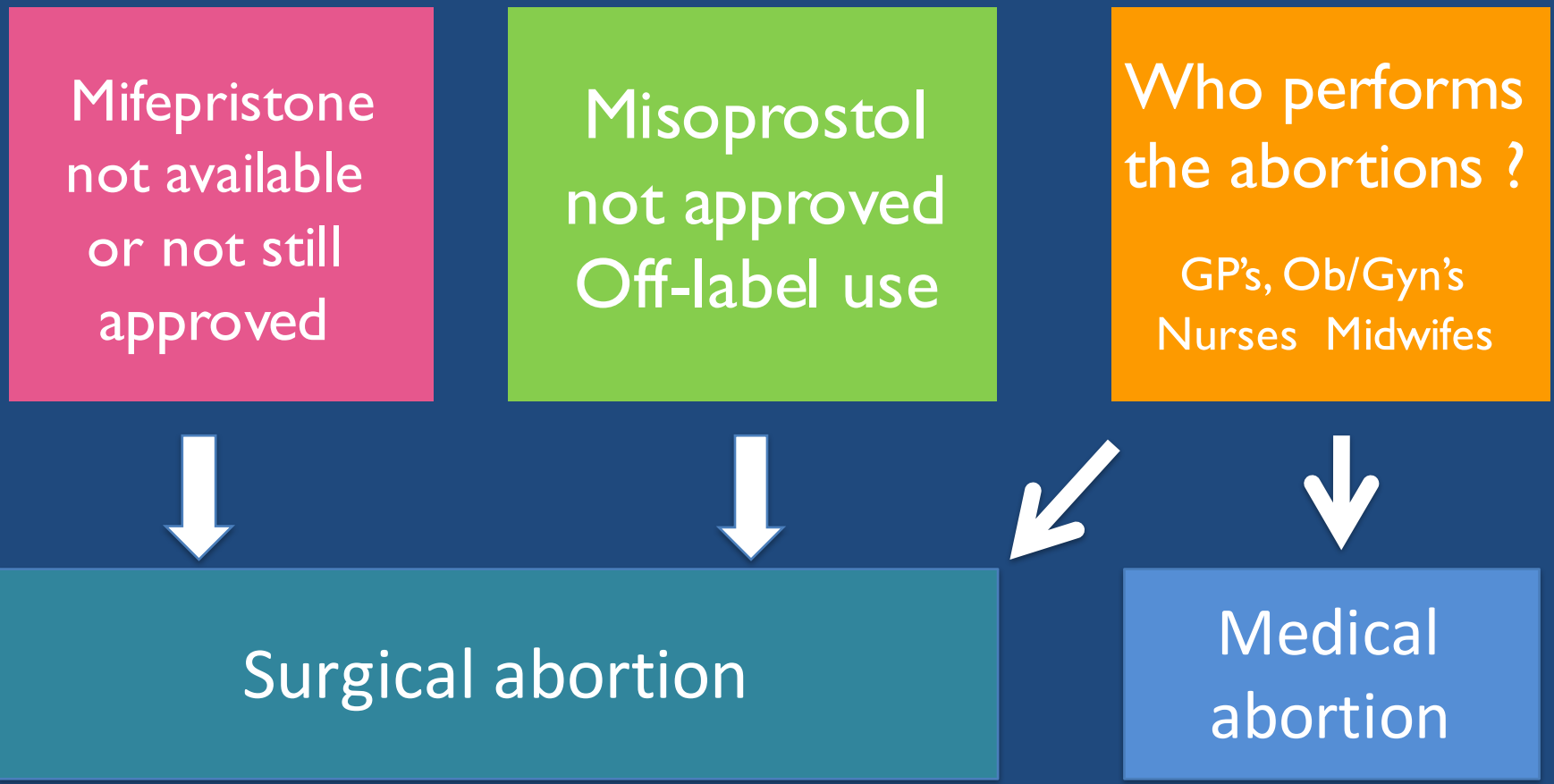
Mandatory waiting periods to perform abortion in Europe

days	countries
0	Austria Denmark Finland Norway Sweden Switzerland Island Moldova UK Poland Romania Serbia Turkey Cyprus Estonia Bulgaria Bosnia/H. Macedonia Czech Republic
2	Slovakia Russia (+ 12 weeks)
3	Germany Spain Hungary Latvia Portugal
5	Netherlands
6	Belgium
7	Albania France Italy Russia (- 10 weeks of gestation)
10	Lithuania (not officially, but common)

Where are abortions performed in Europe ?

public hospitals	Italy Finland Scotland Denmark Norway Island Slovenia Hungary Poland Czech Republic Bosnia/Herzegovina
+ public hospitals − private clinics	Sweden France Portugal Wallonia/Belgium Lithuania Bulgaria Russia Ukraine Scotland Macedonia Serbia
+ private clinics − public hospitals	Austria Germany Holland England/Wales Spain Romania Flanders/Belgium Greece Cyprus Turkey Estonia Lithuania Moldova
private clinics **in another country**	Poland Malta Ireland Nothern Ireland

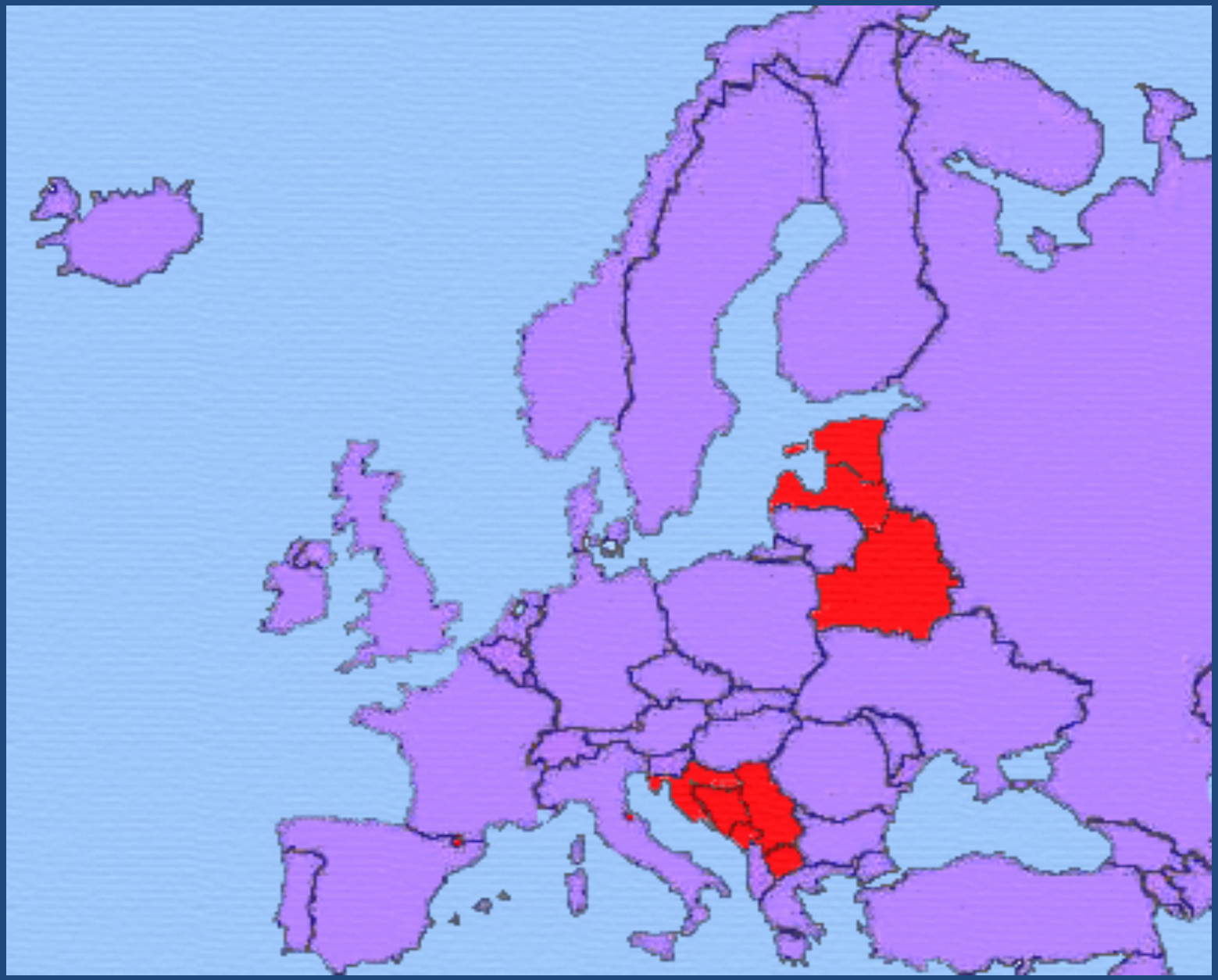
Main reasons for the use of medical vs. surgical method in Europe



Mifepristone and Misoprostol Approval in 16 European countries (Exelgyn 2016)

COUNTRY	Mifegyne approval	MisoOne Approval	
AUSTRIA	21/9/99	Topogyne	17/12/12
BELGIUM	22/11/99	Topogyne	29/1/13
BULGARIA	11/12/12	Topogyne	7/10/13
CROATIA		Mispregnol	6/6/16
CZECH REPUBLIC	5/6/13	Mispregnol	5/6/13
DENMARK	27/8/99	MisoOne	8/5/13
ESTONIA	6/6/03	Topogyne	30/11/12
FINLAND	31/1/00	Misoone	On-going
FRANCE	28/12/88	MisoOne	3/5/13
GERMANY	19/8/99	MisoOne	27/3/13
GREECE	18/10/99		
ITALY	17/12/09	Misoone	18/3/14
LATVIA	5/8/02	Misoone	13/2/13
LUXEMBOURG	11/12/00	Topogyne	1/7/13
NETHERLANDS	25/8/99	MisoOne	4/12/12
NORWAY	29/3/99	Misoone	2/7/13
PORTUGAL	16/2/09	Topogyne	On-going
ROMANIA	11/6/08	Topogyne	18/4/13
SLOVAKIA	31/12/12	Mispregnol	4/6/14
SLOVENIA	14/8/13	Topogyne	14/8/13
SPAIN	21/10/99	MisoOne	28/5/14
SWEDEN	4/9/92	Topogyne	23/11/12
UNITED KINGDOM	1/7/91	Topogyne	18/1/13

Misoprostol **not** approved (Gynuity , updated Feb.2015)



Estonia
Latvia
Poland

Croatia
Serbia
Bosnia /Herzg.
Macedonia
Montenegro

Mifepristone approvals

1988
- China
- France

1991
- UK

1992
- Sweden

1999
- Austria
- Belgium
- Denmark
- Finland
- Germany
- Greece
- Iceland
- Israel
- Luxembourg
- Netherlands

- Russia
- Spain
- Switzerland

2000
- Norway
- Taiwan
- Tunisia
- US

2001
- New Zealand
- South Africa
- Ukraine

2002
- Belarus
- Georgia
- India
- Latvia
- Serbia
- Vietnam

2003
- Estonia

2004
- Guyana
- Moldova

2005
- Albania
- Hungría
- Mongolia
- Uzbekistan

2006
- Kazakhstan

2007
- Armenia
- Kyrgyzstan
- Portugal
- Tajikistan

2008
- Nepal
- Romania

2009
- Cambodia
- Italy

2010
- Zambia

2011
- Ghana
- Mexico
- Mozambique

2012
- Australia
- Bangladesh
- Ethiopia
- Kenya

2013
- Azerbaijan
- Bulgaria
- Czech Republic
- Slovenia Slovakia
- Uganda
- Uruguay

2014
- Thailand

2015
- Canada

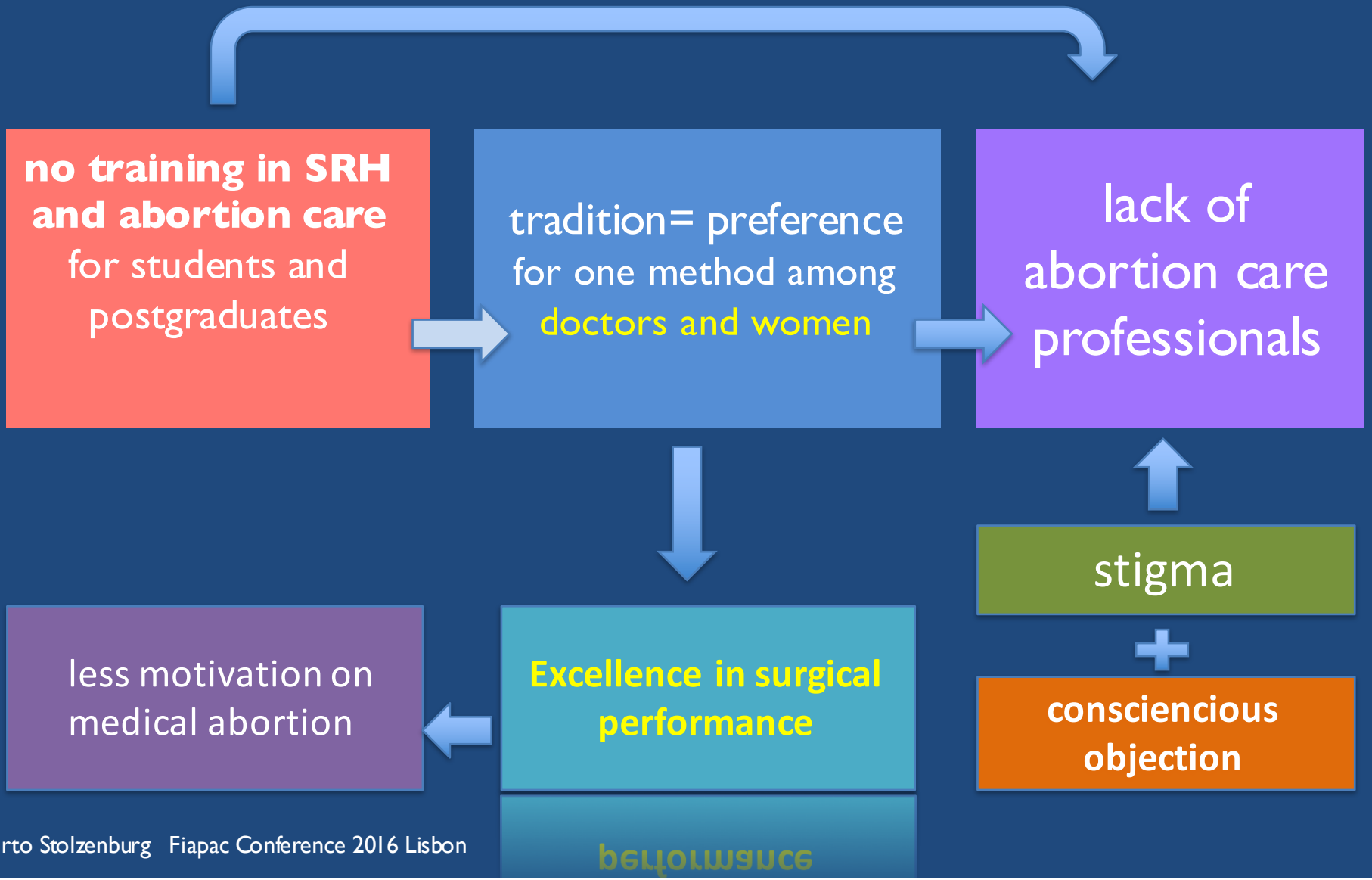
2015 Europa: 31 countries World: 62 countries

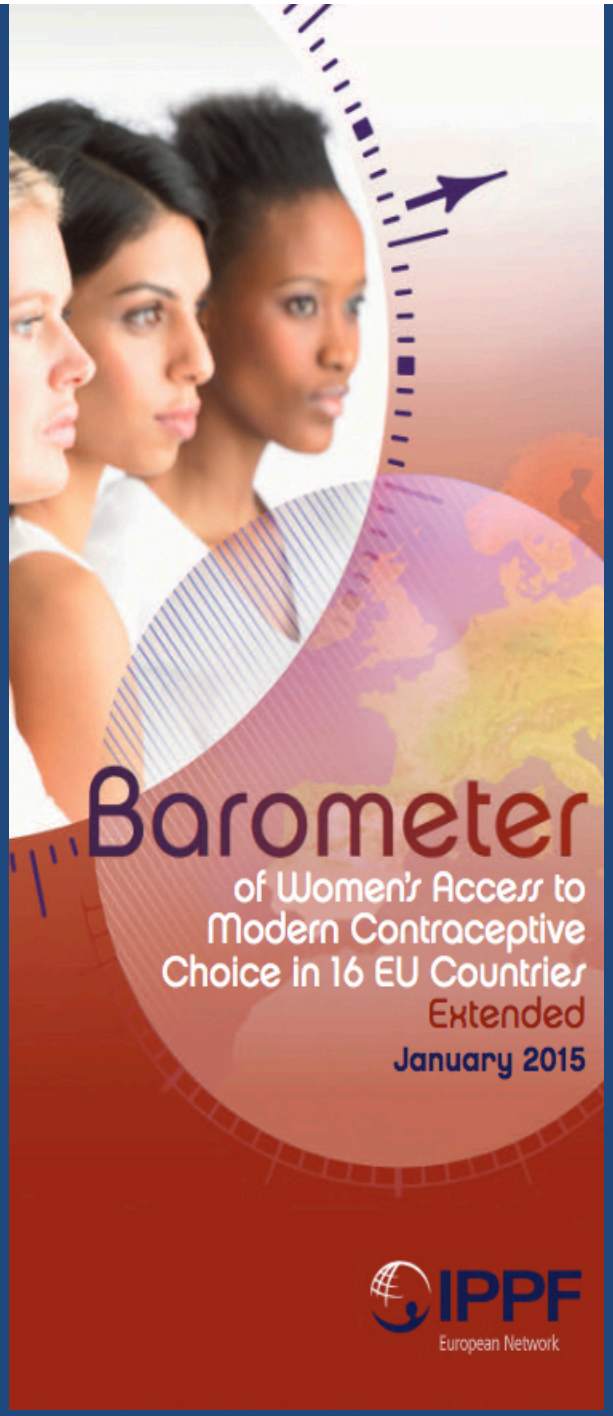
Gynuity HEALTH PROJECTS

Who performs the abortions in Europe?

Gynecologist	Sweden Finland Italy Slovenia Estonia Greece Albania Bulgaria Czech Republic Macedonia Moldova Cyprus
Gynecologist GP	France Belgium UK Germany Switzerland Spain Holland Norway Portugal Island Latvia Lithuania Romania Turkey Serbia Russia Ukraine Bosnia/H. Greece
Midwife Nurse	France Sweden Belgium Scotland (on medical abortion)

Main reasons for the use of medical vs. surgical method in Europe

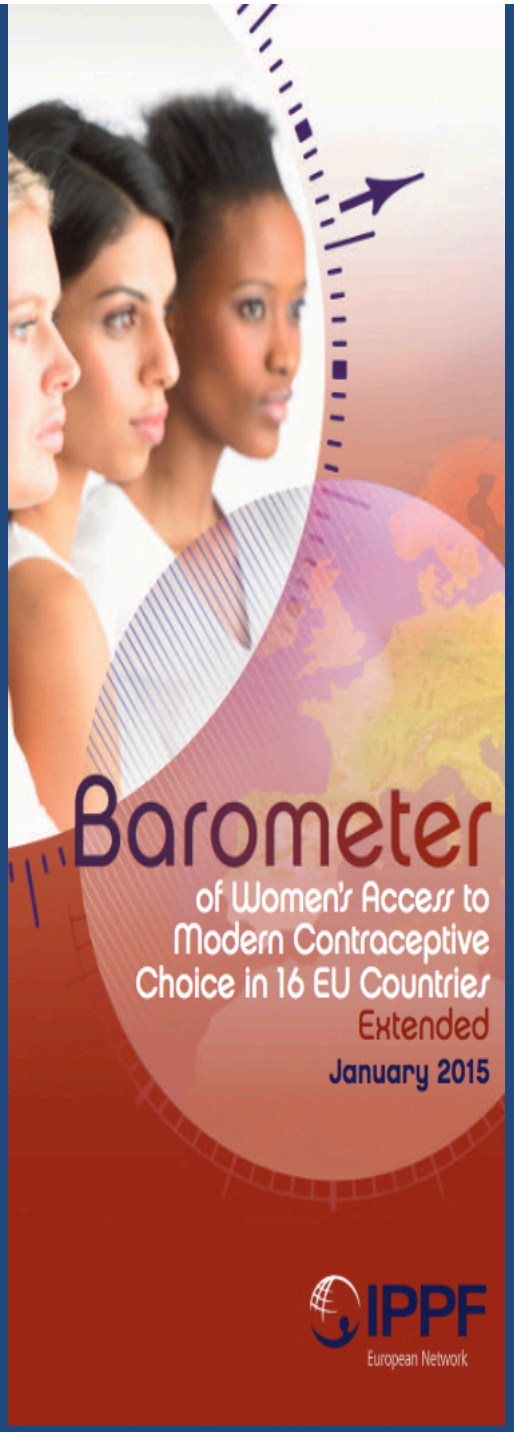




Postgraduate training programmes for healthcare professionals

Exist and organised every year	CZ SE
Exist and organised every few years	BG ES IE NL
Exist but not regularly organised	PL FR LV FI
Do not exist	DE LT IT RO CY DK

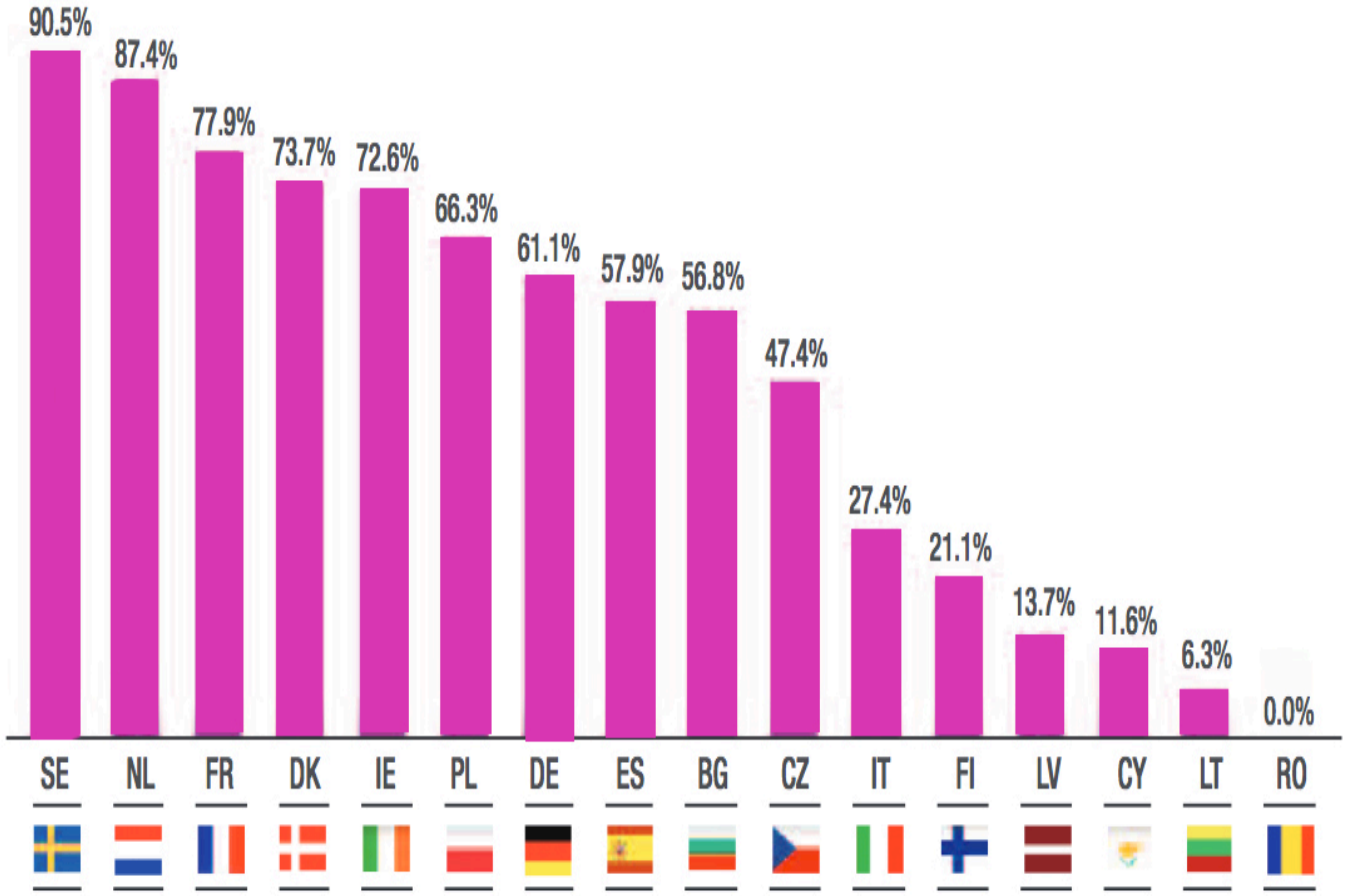
IPPF Barometer 2015 : Women's Access to Modern Contraceptive Choice in 16 EU Countries

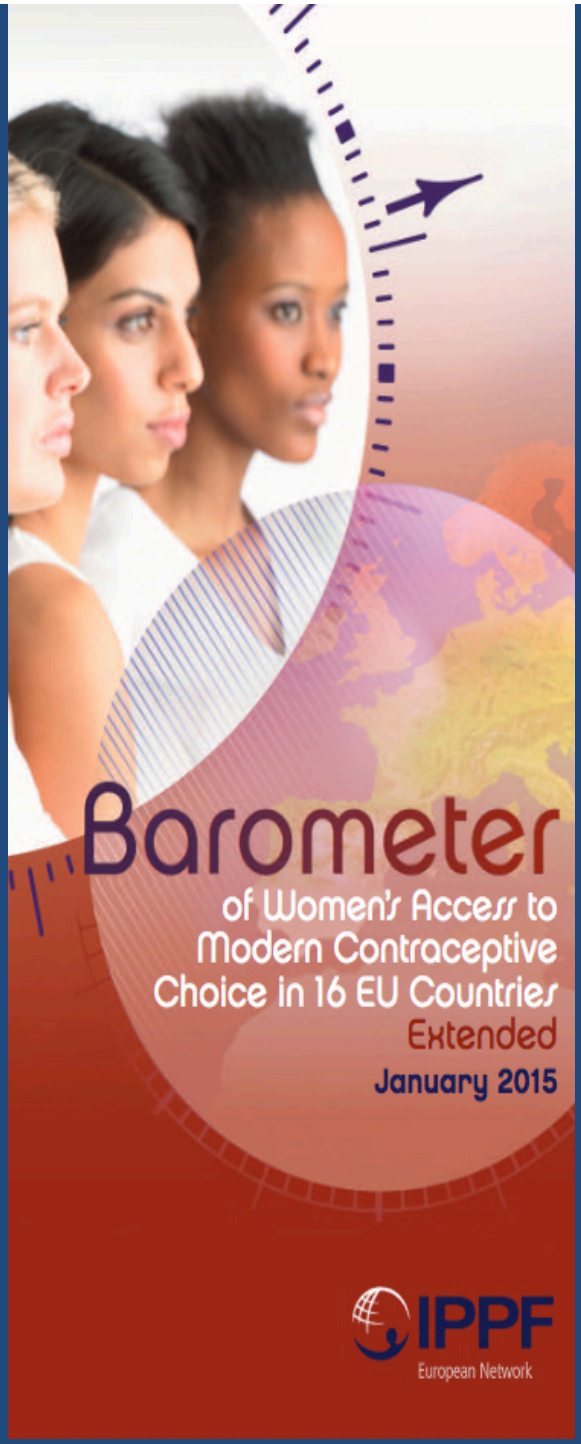


IPPF Barometer 2015

Education and Training of Healthcare Professionals and Service Providers

Policy Benchmark results by country

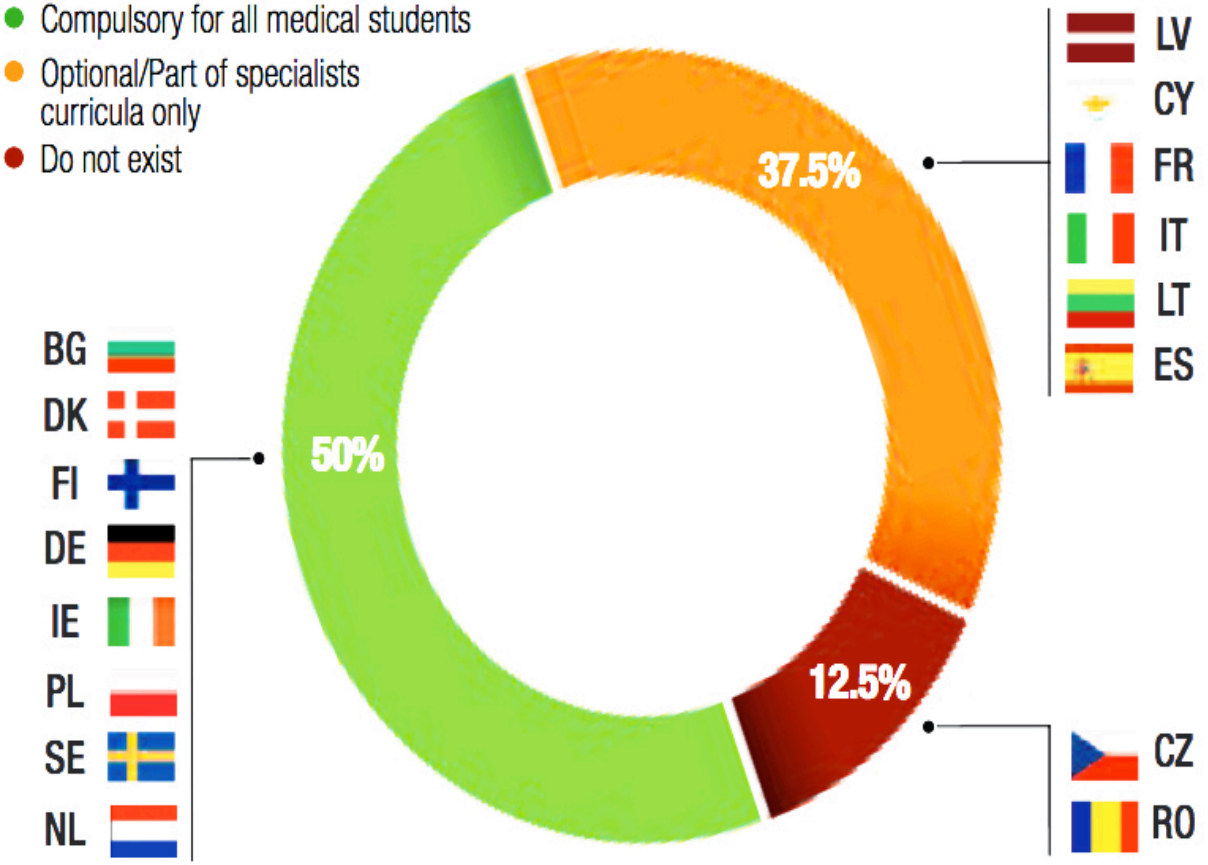


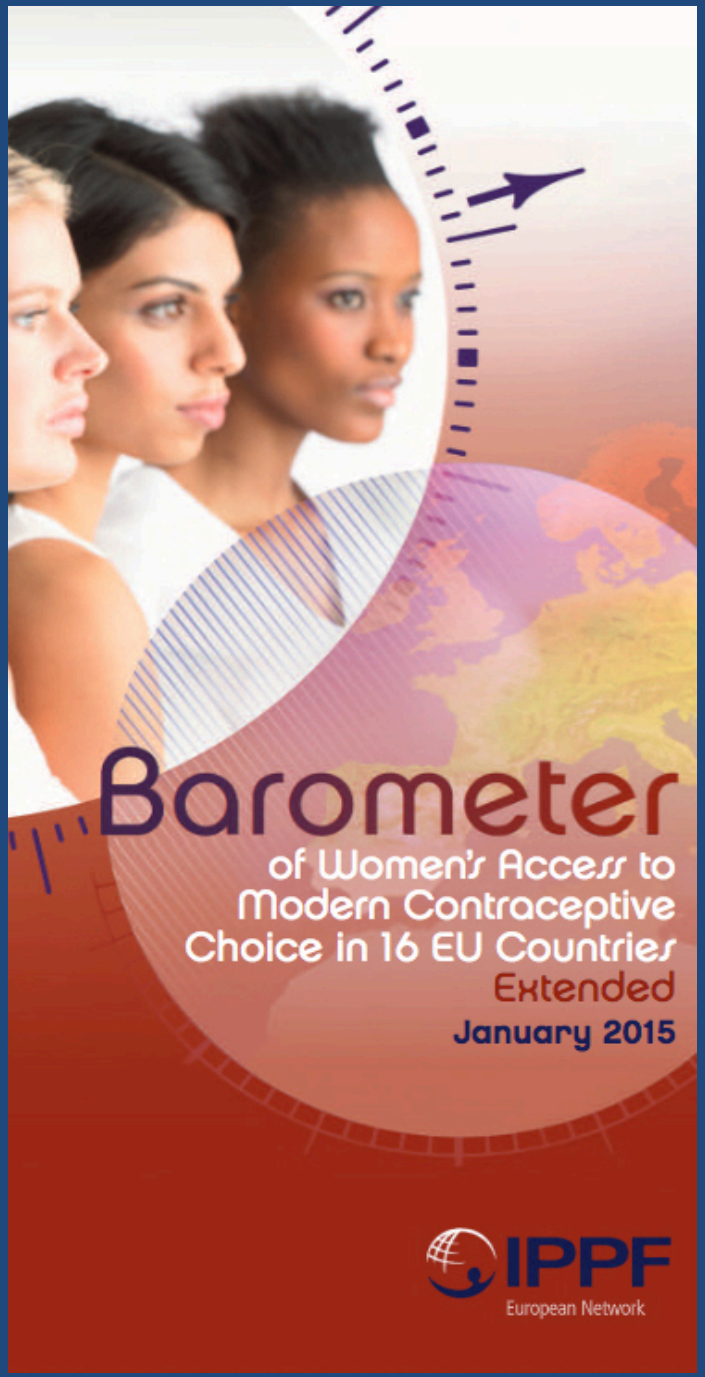


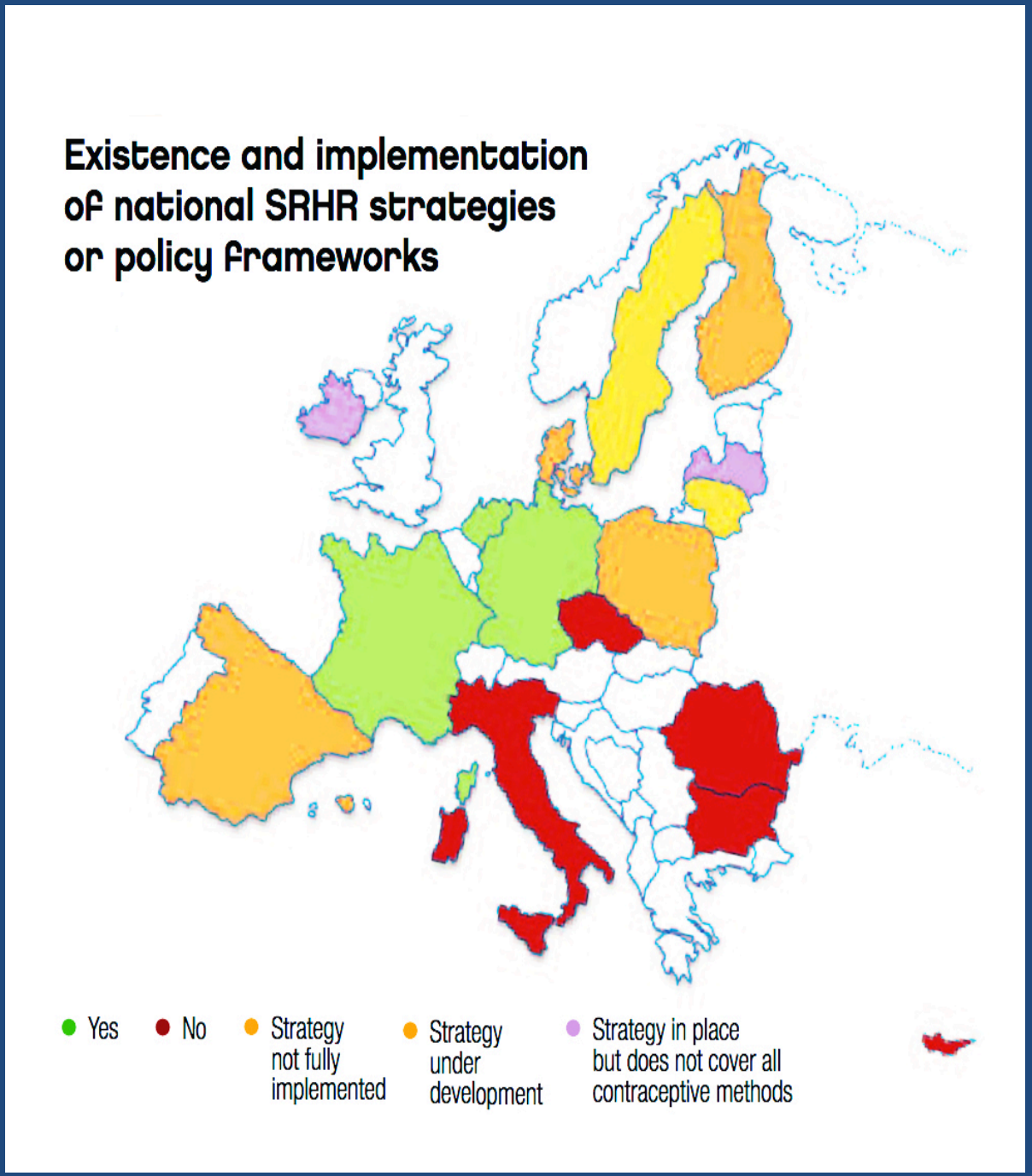
IPPF Barometer 2015 16 EU countries

Existence of education programmes on fertility control/family planning and modern contraceptive choice for medical students

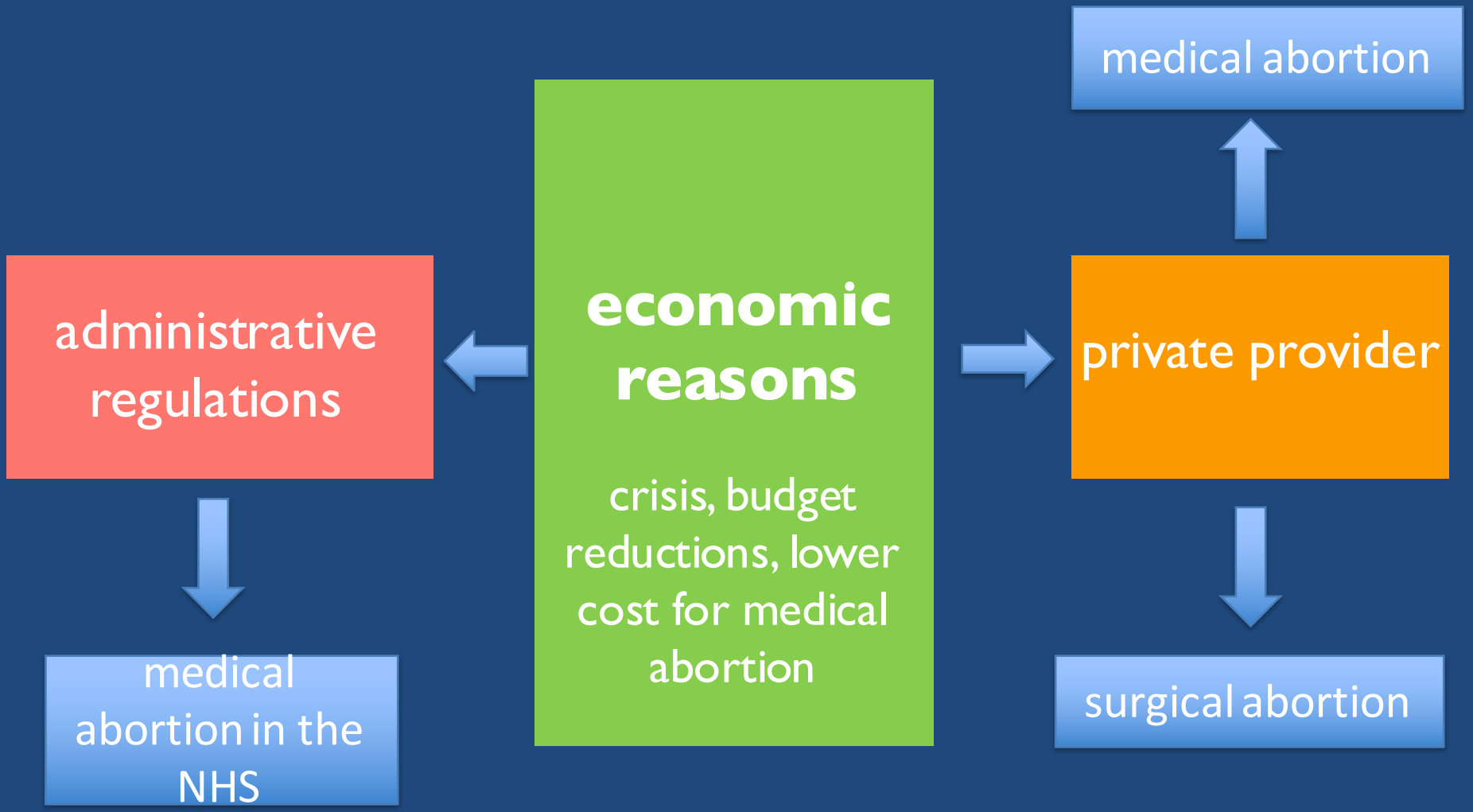
- Compulsory for all medical students
- Optional/Part of specialists curricula only
- Do not exist




Barometer
of Women's Access to Modern Contraceptive Choice in 16 EU Countries
Extended
January 2015
IPPF
European Network


Existence and implementation of national SRHR strategies or policy frameworks
Yes
No
Strategy not fully implemented
Strategy under development
Strategy in place but does not cover all contraceptive methods

Main reasons for the use of medical vs. surgical method in Europe



Who pays the abortions in Europe ?

National Health Service Social Security	Sweden, Belgium, Island, Slovenia, Italy Holland, Switzerland, Denmark, Finland Norway, Scotland, Spain, Portugal, Poland
+++ NHS/SS + women	France, England/Wales, Finland Albania, Turkey, Ukraine
+++ women + NHS/SS	Germany, Bulgaria, Czec Rep., Estonia Greece, Hungary, Moldova, Romania Slovakia , Russia, Serbia , Greece
women	Austria, Nothern Ireland, Cyprus, Lithuania, Letonia, Macedonia, Bosnia/H.

Abortion practice in Europe 2015:
Surgical vs. medical method

surgical method
(¿misoprostol ?)

Lithuania Macedonia Albania
Turkey Czech Republic Hungary
Slovakia Poland Bosnia Herzegovina

+ surgical method
− medical method

Austria (95%) Denmark (60%) Russia (84%)
Estonia (56,2%) Island (85%) Latvia

Switzerland (70%) Belgium (75%) Germany (80%)
Bulgaria(95%) Italy (90%) Holland (75%)

Spain (85%) Greece (90%) Moldova (85%)
Romania (90%) Cyprus Serbia Ukraine(79%)

+ medical method
− surgical method

Finland (90%) France (56%%)
Norway (84%) Switzerland (70%)

Sweden (90%) Portugal (70%) Scotland (81%)
England/Wales (55%) Slovenia (80%)

Do women have a free choice in Europe ?

Opinions of 27 experts on abortion and contraception from 27 countries

yes	Slovenia Belarus Romania Ukraine Greece
mainly yes	Spain Germany Belgium Russia Sweden France Finland Moldova England/Wales Norway Switzerland Turkey Switzerland
mainly no	Austria Latvia Scotland
no	Portugal Italy Netherlands Luxembourg Bulgaria Poland

Comparison on abortion practice between France Germany Spain Portugal

Country	Absolute number abortions	Abortion rate /1000 aged 15-49	Private outpatient clinics and hospitals	% medical abortion	% surgical abortion	Free choice for women
France	2015 203 500	2015 14,4	20 %	56 %	44 %	mostly no
Germany	2014 99200	2012 7,2	97 %	20 %	80 %	mostly yes
Spain	2014 94 796	2014 10,46	90 %	15 %	85 %	mostly yes
Portugal	14 635 2015	6,7	30 %	70 %	30 %	mostly no

bibliography

HCE|fh

HAUT CONSEIL à l'EGALITE ENTRE LES FEMMES ET LES HOMMES

Rapport relatif à l'accès à l'IVG

Volet 2 :
Accès à l'IVG dans les territoires

Rapport n°2013-1104-SAN-009 publié le 7 novembre 2013

En réponse à la saisine
de la Ministre des Droits des femmes,
Madame Najat Vallaud-Belkacem
Danielle BOUSQUET, présidente du Haut Conseil à l'Égalité entre les femmes et les hommes, et **Françoise LAURANT**, présidente de la Commission : Santé, droits sexuels et reproductifs.

A. Le choix de la méthode IVG et de l'anesthésie : enjeu majeur d'une prise en charge de l'IVG de qualité

1. Le choix de la méthode de l'IVG n'est pas toujours garanti

Ainsi que nous l'avons expliqué plus haut, les mêmes choix de méthode ne sont pas possibles dans l'ensemble des structures.
Les IVG chirurgicales ne sont praticables qu'en établissements de santé, quand les IVG médicamenteuses peuvent être réalisées partout.

Le choix de la méthode, une recommandation de la Haut Autorité de Santé

D'après la HAS :

> *« Dans tous les cas où cela est possible, la femme doit pouvoir choisir la technique, médicale ou chirurgicale, ainsi que la méthode d'anesthésie, locale ou générale. »*

La diversification des modes de prise en charge de l'IVG médicamenteuse et instrumentale, au sein de tous les établissements la pratiquant est par ailleurs l'une des quatre orientations nationales présentées dans le guide des Schémas Régionaux d'Organisation des Soins (SROS), élaboré par la Direction Générale de l'Offre de Soins (DGOS)[50].

Le tableau ci-après (page 68) identifie les raisons qui peuvent orienter les femmes – au-delà du terme de la grossesse – dans leur choix de méthode d'IVG.

(50) DGOS, Guide méthodologique pour l'élaboration du SROS PRS, version 2.1, 2011

Total number and location of abortions in Spain 2014

n= 93 279

Surgical method 85%

Public hospital	1,65 %
Public outpatient facility	1,03%
Private hospital	8,17%
private outpatient facility or practice	89,11%

Public sector

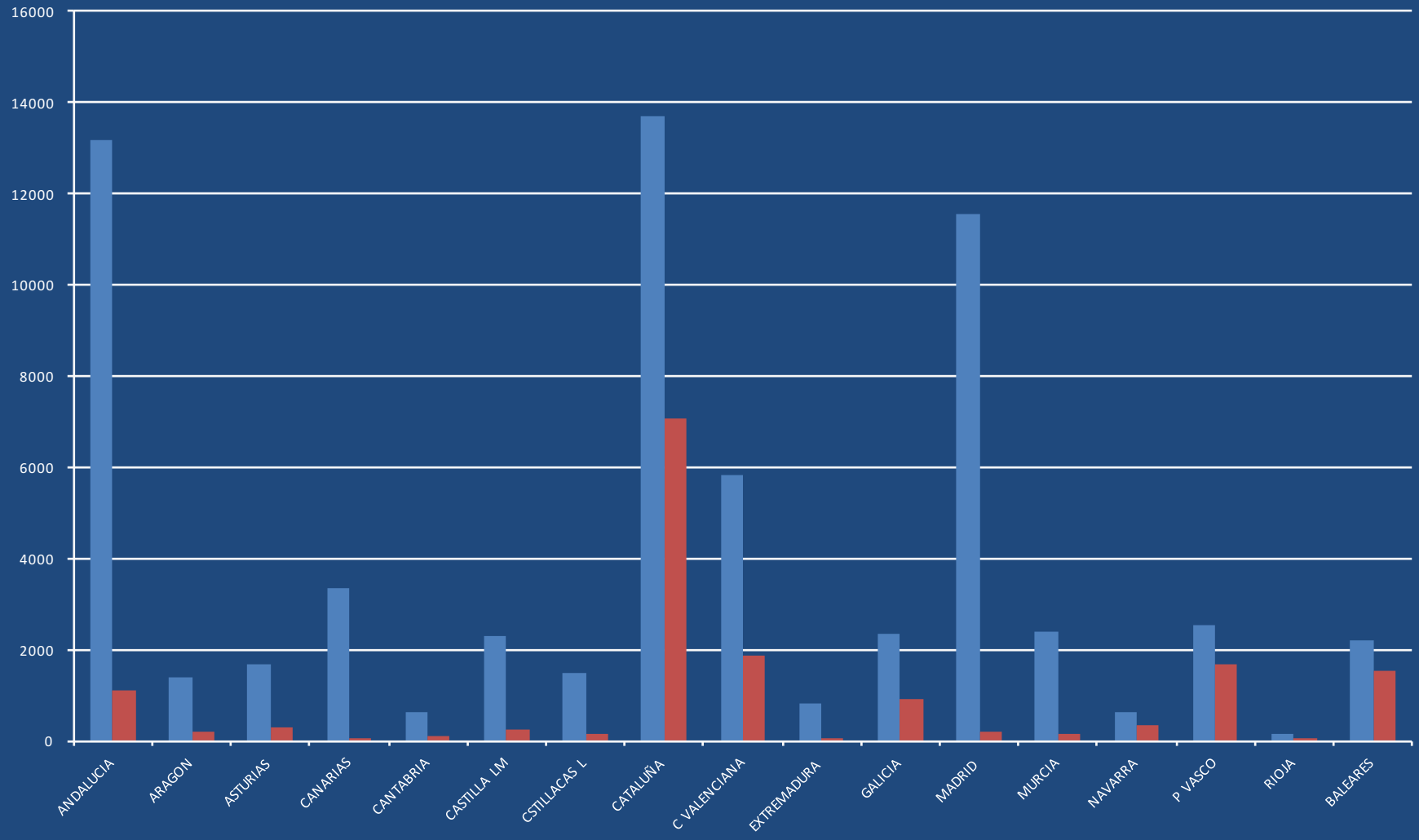
10,09 %

Private sector

89,91%

Medical vs. surgical abortion up to 9 weeks in Spain 2014

Total number 93 279



DR.J. M. MARÍ JUAN / Ministerio de Sanidad, Servicios Sociales e Igualdad. IVE, 2014

Medical abortion

Total number

Medical vs. surgical abortion : comparing satisfaction of women

Studies and reviews	year	number of cases	satisfaction medical	satisfaction surgical
"Comparison between medical and surgical abortion methods and the women's valuation". ACAI (www.acaive.com)	2014	1003	7,9 of 10 VAS	9 of 10 VAS
"Motivation and satisfaction with early medical vs. surgical abortion in the Netherlands." OE Loeber/ Reproductive Health Matters	2010	501	64.2 %	84,2 %
"Medical vs. surgical abortion: the importance of women's choice." C Moreau, J Trussell et al, Contraception	2011	8245 (50 % of women had free choice)	higher (?) under women who had free choice	lower by free choice
"Randomised preference trial of medical versus surgical TOP less than 14 weeks of gestation". Robson SC, Kelly T et al, Health Technol .Assess.	2009	1877	lower	higher
"The choice of second trimester abortion methos: Evolution, evidence and ethics". DA Grimes, Reproductive Health Matters	2008	review	better if doctors are not trained	D +E better if doctors are trained

Medical vs. surgical abortion : comparing satisfaction of women

Studies and reviews	year	number of cases	Medical method	Surgical Method
"Surgical vs. medical methods for second trimester induced abortions" Lohr PA, Hayes JL, Gemzell-Danielsson K	2007	review	"Effective + acceptable" but…	D+E preferable 2 T
"Medical versus surgical methods for first trimester termination of pregnancy" WHO	2006	review	74 % would prefer same method	87 % would prefer same method in future
"Medical versus surgical abortion: comparing satisfaction and potential confounders in a partly randomized study" Rorbye C,Norgaard M, Nilas L,Human Reproduct.	2005	1033	82 % after election of method 68 % after randomization	92 % after election of method 94 % after randomization
"Acceptability of suction curettage and mifepristone abortion in the US: a prospective comparison study" Jensen JT, Harvey SM et al	2000	296	greater 8,6 % would change method In future	Lower 41,7% would change method in future
"Psychological outcomes of medical vs.surgical elective first trimester abortion"	2012	review	Lower levels of anxiety	Higher levels

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Reproductive Health Matters 2010;18(35):145–153
0968-8080/10 $ – see front matter
PII: S0968-8080(10)35501-7

REPRODUCTIVE HEALTH matters
www.rhmjournal.org.uk

Motivation and satisfaction with early medical vs. surgical abortion in the Netherlands

Olga E Loeber

Medical Doctor, Mildred-Rutgershuis, Arnhem, Netherlands. E-mail: loejet@wxs.nl

Abstract: *In the Netherlands, most abortions of early pregnancies have been with electric vacuum aspiration (VA). A study was conducted on women's motivations for choosing surgical (VA) or medical abortion and extent of satisfaction with the method chosen. Information was also collected about the proportion of medical abortions to total abortions in the Netherlands and, for comparison, in some other European countries. Of 501 women with early abortions surveyed in 2008/09, 71% opted for VA. Except for "previous experience", women had different motivations for preferring one or other method. At the post-abortion check-up, satisfaction with the medical method was lower compared to VA. Nevertheless, 80% of those who chose medical abortion would do so again. Nineteen out of 20 doctors questioned at a meeting on abortion offered surgical and medical abortion. Seven of the 11 who gave an opinion found medical abortion an excellent alternative and four thought having the choice was important. The proportion of medical abortions per clinic ranged from <1% to 33%. The proportion of medical vs. surgical abortions in all the countries looked at is influenced by provider attitudes and service-related factors. The use of medical abortion in the Netherlands might increase over time but is unlikely to rise as high as in some other European countries.* ©2010 Reproductive Health Matters. All rights reserved.

Bibliography

OE Loeber / Reproductive Health Matters 2010;18(35):145–153

Table 3. Satisfaction with the method used, preference if they had to choose again, better or worse experience than expected

	Medical abortion			Surgical abortion		
	Satisfaction with the method (n=109)	Would choose this method again (n=106)	Better than expected (n=108)	Satisfaction with the method (n=76)	Would choose this method again (n=88)	Better than expected (n=183)
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Yes/better	70 (64.2)	83 (78.3)	44 (40.7)	64 (84.2)**	74 (84.1)**	139 (76.0)**
No/worse	24 (22.0)	23 (21.7)	48 (44.4)	4 (5.3)**	1 (1.1)**	27 (14.8)**
More or less/don't know	15 (13.8)	0 (0.0)	16 (14.8)	8 (10.6)	13 (14.8)	17 (9.3)

**p<0.01

Bibliography

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Surgical versus medical methods for second-trimester induced abortion

For second-trimester induced abortion, dilation and evacuation is superior to medical methods of abortion. However, specialized training and consistent practice are needed to perform this method safely. Where practitioners with appropriate skills and experience are unavailable, medical methods may be more appropriate.

RHL Commentary by Cheng L

1. EVIDENCE SUMMARY

The aim of this review (1) was to compare efficacy, side-effects, adverse events, and acceptability of surgical and medical methods of inducing abortion during the second trimester of pregnancy. Randomized controlled trials comparing any surgical method of abortion to any medical method of abortion at ≥ 13 weeks' gestation were included.

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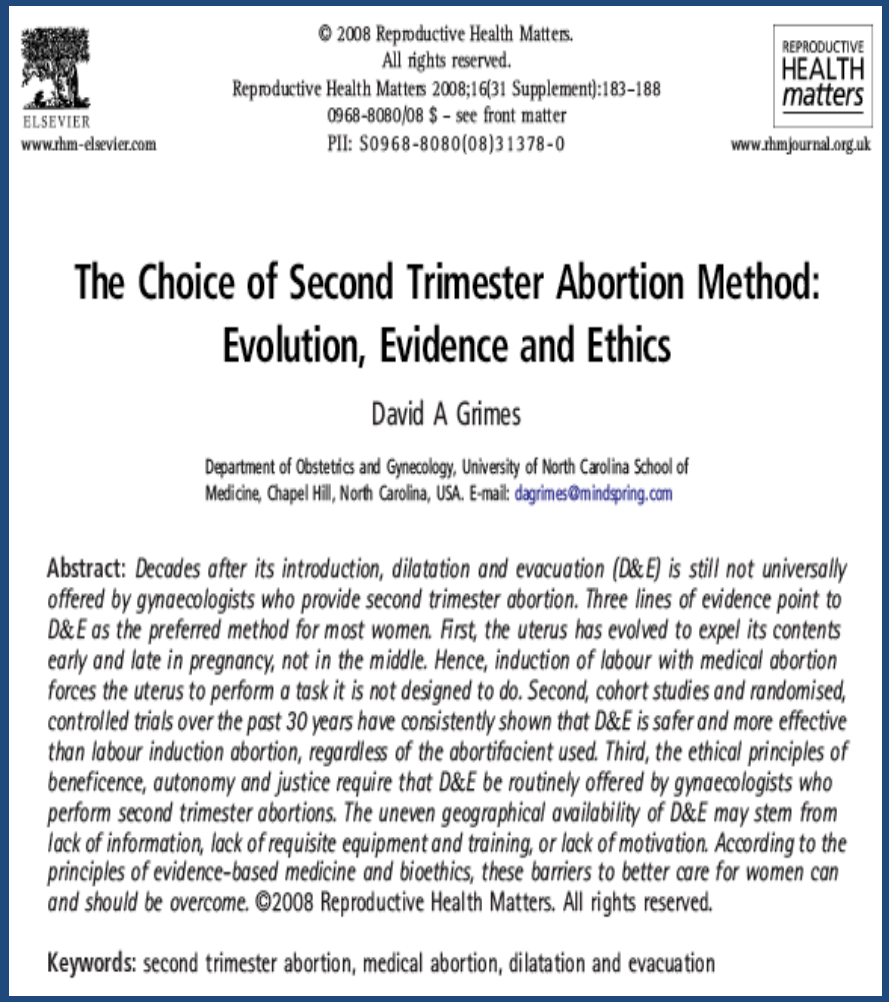

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0968-8080/08 $ – see front matter
PII: S0968-8080(08)31378-0

REPRODUCTIVE HEALTH matters
www.rhmjournal.org.uk

The Choice of Second Trimester Abortion Method: Evolution, Evidence and Ethics

David A Grimes

Department of Obstetrics and Gynecology, University of North Carolina School of Medicine, Chapel Hill, North Carolina, USA. E-mail: dagrimes@mindspring.com

Abstract: *Decades after its introduction, dilatation and evacuation (D&E) is still not universally offered by gynaecologists who provide second trimester abortion. Three lines of evidence point to D&E as the preferred method for most women. First, the uterus has evolved to expel its contents early and late in pregnancy, not in the middle. Hence, induction of labour with medical abortion forces the uterus to perform a task it is not designed to do. Second, cohort studies and randomised, controlled trials over the past 30 years have consistently shown that D&E is safer and more effective than labour induction abortion, regardless of the abortifacient used. Third, the ethical principles of beneficence, autonomy and justice require that D&E be routinely offered by gynaecologists who perform second trimester abortions. The uneven geographical availability of D&E may stem from lack of information, lack of requisite equipment and training, or lack of motivation. According to the principles of evidence-based medicine and bioethics, these barriers to better care for women can and should be overcome.* ©2008 Reproductive Health Matters. All rights reserved.

Keywords: second trimester abortion, medical abortion, dilatation and evacuation

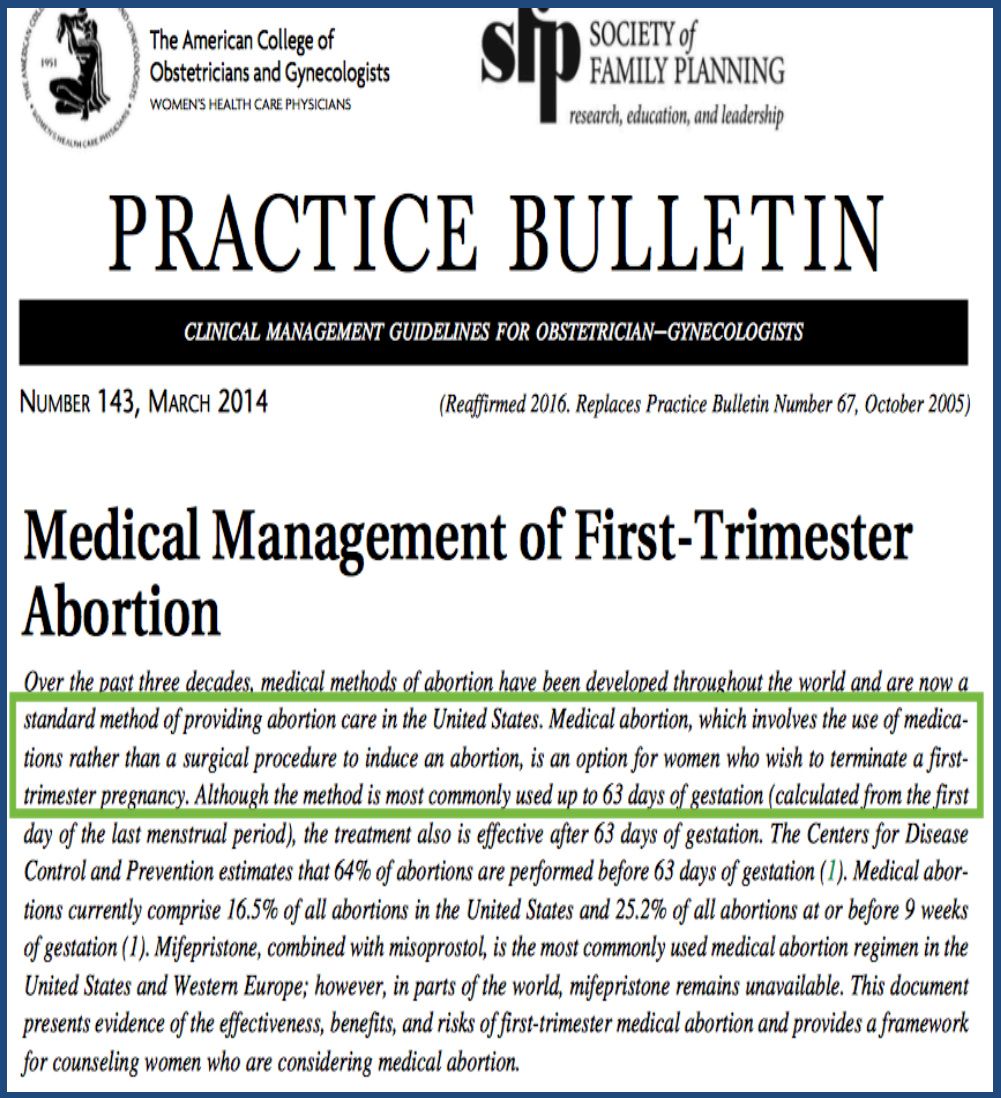
Conclusion

In summary, the uterus evolved to eject its contents early and late in pregnancy, but not in the middle. Hence, bypassing labour is usually the appropriate way to empty the uterus mid-pregnancy. Comparative morbidity and mortality studies over three decades have found D&E superior to medical abortifacients, even modern ones. Finally, ethical principles require physicians to provide patients with the best therapy, let them choose freely among the options, and provide them equal access to best therapy. This means that D&E must be discussed and offered.

In settings with skilled gynaecologists, D&E should be the method of choice for most women; labour induction should also be an option for those who desire it. If the gynaecologist is unwilling or unable to perform the operation, then he or she is ethically obliged to refer the patient to someone who will. In locales without skilled gynaecologists, medical abortion should be the norm, since its singular advantage is that it requires no skill at all to start.

D&E has two prerequisites: an open cervix and an open mind. The uneven geographical availability of D&E today suggests that the latter prerequisite is the more difficult to achieve.

Bibliography



The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

SOCIETY of FAMILY PLANNING
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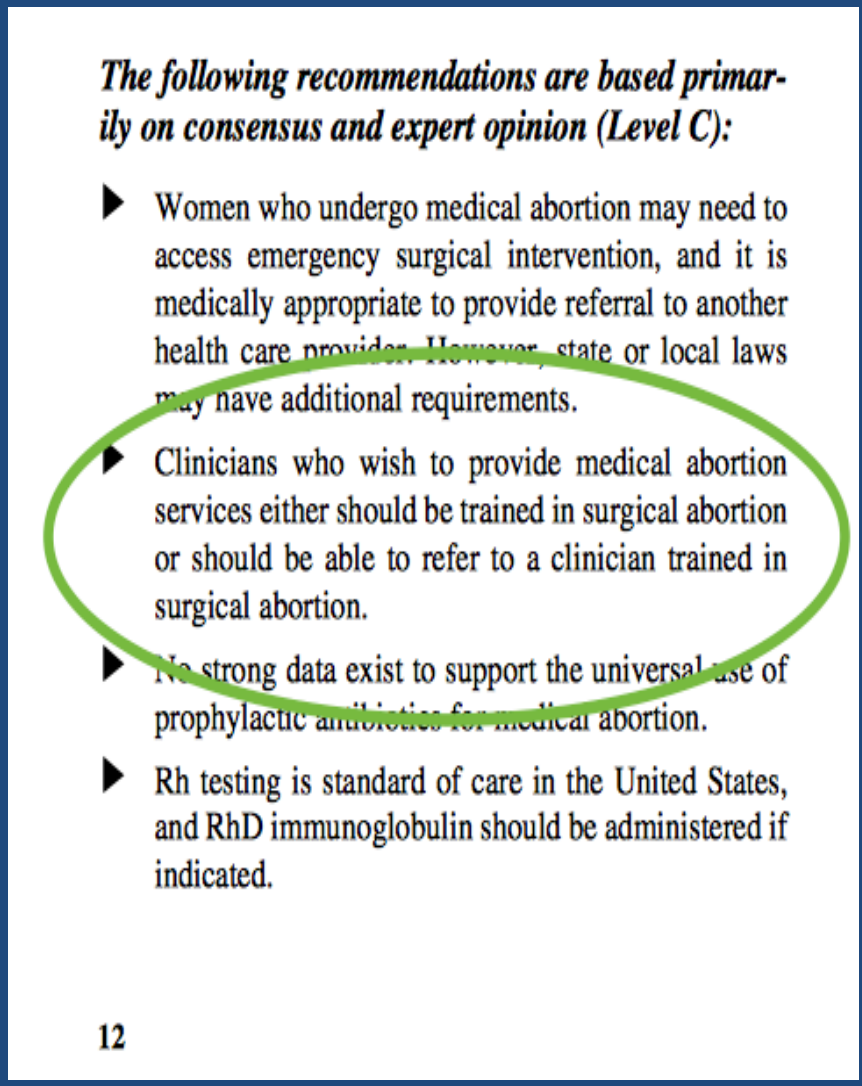
Medical Management of First-Trimester Abortion

Over the past three decades, medical methods of abortion have been developed throughout the world and are now a standard method of providing abortion care in the United States. Medical abortion, which involves the use of medications rather than a surgical procedure to induce an abortion, is an option for women who wish to terminate a first-trimester pregnancy. Although the method is most commonly used up to 63 days of gestation (calculated from the first day of the last menstrual period), the treatment also is effective after 63 days of gestation. The Centers for Disease Control and Prevention estimates that 64% of abortions are performed before 63 days of gestation (1). Medical abortions currently comprise 16.5% of all abortions in the United States and 25.2% of all abortions at or before 9 weeks of gestation (1). Mifepristone, combined with misoprostol, is the most commonly used medical abortion regimen in the United States and Western Europe; however, in parts of the world, mifepristone remains unavailable. This document presents evidence of the effectiveness, benefits, and risks of first-trimester medical abortion and provides a framework for counseling women who are considering medical abortion.



The following recommendations are based primarily on consensus and expert opinion (Level C):

- Women who undergo medical abortion may need to access emergency surgical intervention, and it is medically appropriate to provide referral to another health care provider. However, state or local laws may have additional requirements.
- Clinicians who wish to provide medical abortion services either should be trained in surgical abortion or should be able to refer to a clinician trained in surgical abortion.
- No strong data exist to support the universal use of prophylactic antibiotics for medical abortion.
- Rh testing is standard of care in the United States, and RhD immunoglobulin should be administered if indicated.

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Abortion practice in Europe : Conclusions

Legislation must create regulatory framework to guarantee women`s choice on abortion matters/method

Available evidence based information of high quality on abortion

Education programmes on SRH/abortion care for students of medical professions

Education and training of healthcare professionals on SRH/ abortion care and abortion methods

Abortion care needs special skills : Ob/Gyn specialists are not specialized on abortion care and methods

Medical and surgical methods are not conflicting goals,but complementary

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Thank you for your attention!