SPHERE
NHMRC Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care

Information Brief on Safety of Abortion Care in Australia

Induced abortion (herein referred to as abortion) is a common, essential and safe reproductive service for the termination of pregnancy. The risk of complication from legal abortion is very low, and is in fact, a fraction of that for childbirth[1,2]. Modern approved abortion methods fall into two categories, medical abortion and surgical abortion[3]. In 2014-15, among clients of Australia's largest private abortion provider, just over one-third of eligible women chose to have a medical abortion and the remainder had a surgical abortion[5].

Timely access to abortion care is dependent on a number of factors such as early pregnancy recognition, decision-certainty, and informational, financial and geographical access to abortion services, among other things. Data from high income countries that have liberal legal frameworks on abortion and accompanying provision of abortion care, indicate that overwhelming 90% of all abortions occur within the first 13 weeks of pregnancy, with two-thirds of all abortions occurring within nine weeks gestation[4]. Delays in access to abortion care are often linked to factors such as young age, and structural barriers like poverty and geography, which if addressed, can improve equity in early access[5, 6].

Safety of early medication abortion in Australia

Medical abortion in early pregnancy (≤ 63 days gestation) uses a combination of two drugs: the first is mifepristone, which is orally administered in a 200-milligram dosage to stop the pregnancy from continuing, by blocking the hormone progesterone. The second drug is misoprostol, which is taken in an 800-microgram dosage, 24-48 hours after mifepristone. Within hours of taking misoprostol, most women experience bleeding and uterine cramping, which are normal symptoms of the medical abortion process, and similar to experiencing a spontaneous miscarriage. Evidence of a successful termination can occur through ultrasonography, a serum beta-hCG test* or a urine pregnancy test[7]. Both mifepristone and misoprostol are included in the World Health Organization's *Model List of Essential Medicines,* as life-saving medications, based on substantial worldwide evidence documenting their safety and efficacy in protecting women's health and lives[8].

In Australia, the combination regimen of mifepristone and misoprostol (referred to as MS-2 Step) for termination of intrauterine pregnancies up to 63 days gestation was approved by the Therapeutic Goods Administration in 2014[9]. The use of MS-2 Step for early medical abortion (EMA) is backed by a robust body of scientific data on its safety and efficacy in Australia and overseas[10-12]. In a recent Australian study of 13,078 women, 95.2% had successful medical abortions, with the remaining 4.8% accessing additional surgical intervention[12].

* This is a blood test that measures the amount of the hormone beta-hCG in the blood. It is produced by the placenta during pregnancy, and its detection can confirm or rule out pregnancy.

Importantly, the likelihood of experiencing infection or excessive bleeding requiring transfusion was extremely low.

The high success rate of EMA in Australia is very consistent with international data[11]. In comparison to the surgical procedure, medical abortion's relatively simple protocol has enabled decentralized provision of EMA by certified and/or registered general practitioners in all states and territories except for South Australia [7]. Expansion of EMA into general practice is in line with recommendations from the World Health Organization (WHO) that abortion must be affordable, accessible and available in primary care[13, 14].

Safety of early medical abortion by telehealth in Australia

Telehealth —using telecommunication technology for the provision of remote medical care — has evolved as a promising and efficient strategy for delivery of EMA to women who face access barriers. In Australia, this strategy for service delivery may be particularly useful for women living in regional and remote parts of the country[15]. Clinical consultations occur over the phone, following the same high standards for eligibility assessment and counselling as in-person consultations. If clinical criteria are met, the treatment is discussed with the client and medications shipped to her so that she can undergo the abortion safely and in the privacy of her home, with access to around-the-clock guidance via a nurse aftercare service and to emergency care[16]. Evaluations of telehealth EMA services in Australia and some US states show that it is safe and effective, with no significant differences in health outcomes compared to in-person care[17-19]. Importantly, Australian women who have used the service find it private, acceptable, and are highly satisfied with its quality[20].

Safety of surgical abortion

Surgical abortion is a commonly utilised gynaecological procedure in which the cervix is dilated, and the contents of the uterus evacuated by vacuum aspiration. This procedure is used for abortion and as a treatment intervention for incomplete EMA or miscarriage. Surgical abortions up to 14 weeks gestation are minimally invasive and carried out with appropriate pain management. The efficacy rate is high at 99% and serious complications such as haemorrhage, infection or uterine perforation are very rare (<0.1%)[21]. In Australia, women's preferences for the surgical option may be motivated by fewer clinic visits, and perceptions that it is simpler and accompanied by less bleeding in comparison with EMA[5]. On the basis of evidence for the procedure's safety and effectiveness, the WHO recommends that it be provided at the level of primary care[13].

Safety of abortion after 14 weeks

Surgical and medical techniques are also used after 14 weeks. Surgical abortion requires additional cervical preparation and instrumentation in a procedure called dilation and evacuation (D&E)[3]. The risks of this more complex procedure increase with gestational length, while remaining low. When conducted with advanced training, D&E is highly effective and safe, with low rates of complications (range: 0.05 - 4.00%) as documented in the scientific literature[3]. Medical techniques also involve cervical preparation followed by induction of labour. The risks of this procedure are also low. The majority of abortions after 20 weeks are due to fetal anomalies. In Canada, where there is no gestational age limit, less than 1% of abortions occur beyond 20 weeks gestation, and this rate has remained stable for years[22].

Long term outcomes for patients of receiving an abortion

Research in Australia and globally has shown that women weigh a number of health, personal, social and economic factors in making their decisions to undergo abortions[23]. Based on a large US-based study, the overwhelming majority of women who access abortion care consistently indicate over time that it is the right decision for them, while acknowledging mixed emotions in the short term, including the predominant feeling of relief[24]. Importantly, the emotional intensity of the experience declines over time, and there is no evidence of negative psychological responses in the longer term[25]. In the case of reproductive health outcomes, having an abortion does not increase the risk for secondary infertility, hypertensive disorders of pregnancy, or breast cancer[26]. There may be an increased risk of preterm birth following uterine evacuation (for miscarriage or abortion)[27].

Long term outcomes for patients denied an abortion

In the short term, denial of abortion is associated with elevated feelings of distress and anxiety[24]. In the longer term, similar to women who receive abortions, the intensity of emotions of women denied abortions subside, with no indication of long-term psychological harm[25]. However, in comparison with women who access abortions, women denied this service are more likely to experience economic hardship and insecurity in the long term[28]. This outcome is consistent with financial precariousness mostly being the key reason for seeking this healthcare service. Many women also cite reasons related to the well-being of existing children. In a US-based study, over a five-year period, the children of women denied abortions had lower average development scores and were more likely to live in poverty, compared to children of mothers who had access to abortion care[29]. These findings point to the socio-economic consequences on women and their families due to abortion denial.

Professor Angela Taft MPH PhD

Chief Investigator, on behalf of SPHERE NHMRC Centre for Research Excellence, c/o Department of General Practice, School of Primary and Allied Health Care, Building 1, 270 Ferntree Gully Road, Notting Hill, VIC 3168, Australia

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