MEDICAL ABORTION

For Women's Health and Free Choice

Documentation of the Project
»Actions accompanying the Introduction of Medical abortion with Mifegyne (RU 486)«

Sponsored by the Federal Ministry for Family, Senior Citizens, Women and Youth

pro familia
German Society for Family Planning, Sexual Education and Counseling

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Published by pro familia
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This is a documentation of the project »Actions accompanying the Introduction of Medical Abortion with Mifegyne® (RU 486)«. Pro familia initiated this project during the process of registration of Mifegyne in 1999 in order to provide its expertise in dealing with the problems that were to be expected in the course of introducing the drug into the German market.

The project was carried out between November 1999 and December 2000 and was supported by the Federal Ministry for Family, Senior Citizens, Women and Youth.

This documentation particularly focuses on two aspects of the project that should be of interest: the results of surveys among medical facilities and patients on the acceptance of medical abortion with Mifegyne and on current availability (section 2, by Klaus Riemann) as well as the papers and recommendations of the »Conference on Medical abortion with Mifegyne« which was held on 28 October 2000 in Berlin (section 3, compiled by Gundel Koebke). An Introduction by Elke Thoss and Joachim v. Baross deals with the general conditions and problems occurring at the time when Mifegyne was introduced to Germany in 1999 and outlines the situation one year later (section 1). Finally, section 4 presents further aspects and results of the project.

General coordination of the project until August 2000 was - under supervision of management and board of pro familia – carried out by Dagmar Gendera, the training seminars were coordinated by Ingrid Maier during the first two weeks of November 1999 and by Bernadette Stolle between January and April 2000. All of them were employed at the pro familia central office in Frankfurt am Main. Gundel Koebke and Margit Miosga, Berlin, planned and coordinated the »Conference on Medical abortion with Mifegyne«, which was held in Berlin in October 2000. Empirical surveys on the care system and on women who had an abortion were conducted for pro familia by Gesomed Society for Sociological Research in Medicine, Freiburg; the person responsible at Gesomed was Klaus Riemann.

Technical advice was provided by a committee of experts which met three times between December 1999 and April 2000. The committee included:

Hermine Baumann, director of the pro familia counseling center for pregnant women in Munich

Ulrike Busch, board member pro familia and executive director Balance family planning clinic, Berlin

Christian Fiala, physician at Korneuburg Hospital, Vienna, Austria

Kristina Haenel, physician at pro familia medical institute, Giessen

Elfie Mayer, Family Planning Clinic, Hamburg

Ines Thonke, adviser for family planning and health at pro familia, Frankfurt am Main

Joachim v. Baross, deputy executive director, pro familia association, Frankfurt am Main

as well as *Dagmar Gendera* and *Bernadette Stolle*, the coordinators of the project.

We would like to thank all of those mentioned above, and also those who contributed to this project, held talks at and participated in seminars and the conference, informants at counseling and medical centers and last but not least the Federal Ministry of Family, Senior Citizens, Women and Youth – without its financial support this project would not have been possible.

Frankfurt am Main, December 2001

Summary

As Mifegyne was introduced into the German market, pro familia launched a project that was aimed at integrating medical abortion with Mifegyne into the German medical care system as efficiently as possible. The project consisted of training seminars for counselors and physicians, a conference involving a number of international experts, providing information brochures in three languages for clients as well as three surveys among counseling centers, medical centers and patients dealing with availability and acceptability of this method.

The aims of the project were largely achieved. Particularly the training seminars for counselors and physicians as well as the information brochures for clients made it possible for women now to be able to get the information they need to choose in time between medical and surgical abortion and to make their choice based on their individual situation and needs. Also, this project and the conference held in October 2000 created technical preconditions to establish adequate availability of the medical method in Germany.

However, after completing the project, we have to realize that the actual availability of this method is still far from satisfactory. The majority of women do not have the opportunity to choose between medical and surgical abortion. The main reason is that the availability of the medical method is spreading slowly, even declining in some places after a promising beginning. In essence, this is due to the guidelines for reimbursement of medical services. Reimbursement for medical abortions is far lower than compensation for surgical ones and doesn't even fully cover all expenses. This is particularly hard on those women who have no or very little income of their own and who depend on the Federal States to cover the costs via the public health insurance systems. If the problem of compensation will not be solved before too long, there will be a class difference in the field of abortion in Germany. This involves a risk to the health of those women who due to their economic situation cannot choose the abortion method that - according to their individual psychological, physical and social needs – is the most appropriate.

Thus, establishing an appropriate agreement on reimbursement should be the most important goal for pro familia, physicians and government authorities. This is the prerequisite if we want to ensure that women from all walks of life are offered both the medical and the surgical method of abortion.

Another aim of the project, integrating today's know-how on medical abortion with Mifegyne into medical education and training has been achieved, however not to the extent that we believe is necessary. First steps resulted from the discussions during the conference in October 2000 and the recommendations that were defined there and also - on an informal level of professional exchange – from the training seminars that were held in the course of the project.

For the first time in more than a decade[1], the conference on »Medical Abortion with Mifegyne« offered a wide platform of professional exchange for both physicians and counselors. One particularly important aspect that results from the contacts established at the conference is the organization of a national abortion network. The objective is to assure the availability of qualified abortion and to make it an integral part of women's health care.

A number of ideas for further and deeper research have emerged from the project and were included into the recommendations defined at the conference in October 2000. Some of them are

- the possibility of extending the period of time Mifegyne may be applied,
- the dosage of Mifegyne and additional treatment with prostaglandin,
- practical methods of treatment and
- improving the communication between patients and the professionals involved in order to reach a sound decision for the method that is the most suitable for the individual and that is the treatment associated with the least stressful psychological and physical effects.

Also, it would be advisable to repeat the surveys among counseling centers, medical centers and patients dealing with availability and acceptability of abortion with Mifegyne in 2001 – and possibly in the following years as well. Considering that even today the availability of medical abortion with Mifegyne is very limited due to the fact that even now the question of compensation is still not solved, the results of the surveys conducted in the Spring of 2000 are no more than preliminary; they provide only limited information on availability and acceptance of the new method among physicians, counselors and women who want to have their pregnancies terminated.

On account of the findings of the conference, a nation-wide study on medical education and training concerning abortions should be conducted. This study could provide strategies to improve medical qualification in this field which right now is by no means optimal. Also, it could indicate perspectives of what to do about the threat of superannuation among those physicians willing to perform abortions and the limitations in availability that are caused by this process.

[1] On 7 December 1988, pro familia and Berliner Aerztekammer (Berlin Chamber of Physicians) hosted a work shop on »Abortion and Legal Problems for Doctors« in Berlin.

Mifegyne in Germany[2]

Mifegyne in Germany

[2] A first version of this article by Elke Thoss and Joachim v. Baross was published in International Planned Parenthood Federation European Network's magazine, CHOICES 2000 (1).

After controversies lasting for more than a decade, Mifegyne was finally certified for medical abortion in Germany in 1999. Ever since the late 1980s, pro familia and several other social and medical groups had incessantly advocated for the introduction of Mifegyne to Germany, always referring to the women's right to choose among medically proven methods. On the other hand, the various owners of the Mifegyne patent – first Roussel-Uclaf, then Hoechst and eventually Exelgyn – kept refusing to file an application for registration without endorsement by the authorities. The Kohl Administration never agreed to do so until it was voted out of office in 1998. In March 1999 however, the new Chancellor Gerhard Schroeder supported the idea of making Mifegyne available for women in Germany. Thus, the road was clear to include Germany into Exelgyn's application to have Mifegyne certified in Europe. In charge of distribution in Germany was Femagen, a company based near Munich/ Bavaria.

To guarantee a controlled distribution of Mifegyne, an amendment to the German Medication Act was passed in July of 1999. According to this amendment, drugs designed for medical abortions may not be sold in pharmacies but can only be obtained directly from the manufacturer who owns the patent of that drug. Also, to make sure that the medication is used for legal and justifiable abortions, a number of control measures have to be observed.

Political Obstacles

As expected, Anti-Choice groups continued to oppose the issue of introducing Mifegyne to Germany, even after the Schroeder Administration had officially endorsed the drug, Exelgyn's application for certification and Mifegyne having been certified. Groups, who tried to stop Mifegyne by sending postcards to the Chancellor or demonstrating outside Femagen, considered their actions morally justified as individual Roman Catholic bishops called Mifegyne a »pill of death«. With some last-minute legal actions, the State government of Bavaria, where Femagen is based, tried to stop the distribution of Mifegyne. These actions did little more than delay the first deliveries.

Controversies on the period of time Mifegyne may be applied

To everyone's surprise, even the scientific association of gynecologists – the Deutsche Gesellschaft fuer Gynaekologie und Geburtshilfe (DGGG, German Society for Gynecology and Obstetrics), who in 1992 had explicitly supported the introduction of Mifegyne, tried to fend off wide-spread use of the drug. In the Spring of 1999, a DGGG commission recommended withholding treatment with Mifegyne until after the 42nd day LMP. The commission claimed that before this point of time the embryo's cardiac sounds – and thus a living pregnancy – are not detectable. Moreover, the DGGG commission recommended abandoning abortions before the 42nd day LMP all together and to consider this regarding time schedule and contents of pregnancy conflict counseling.

Pro familia examined this study and consulted German and international experts[3], con-

[3] Among those were experts of the World health Organization (WHO), Geneva and of Population Council, New York.

cluding that restricting the use of Mifegyne to the 42nd to 49th day LMP can be justified neither scientifically nor ethically. Consequently, pro familia worked to prevent this restriction from being included into the drug's certification. These efforts, along with similar initiatives made by the Gynecologists' Association, eventually prevailed.

The Project »Actions accompanying the Introduction of Medical abortion with Mifegyne (RU 486)«

Between November 1999 and late 2000, pro familia conducted a project on actions accompanying the introduction of medical abortion. The project was endorsed by the Federal Ministry for Family, Senior Citizens, Women and Youth.

Objectives were

- to provide that women have the opportunity to choose early and within the recommended time frame between medical and surgical abortion, that their choice is based on their individual situation and needs as well as on unbiased information,
- to help establish a system that quickly ensures an appropriate availability of the new method,
- to integrate today's know-how into medical education and training and
- to stimulate research on problems that are yet to be solved.

The following actions were taken:

- between January and March 2000, pro familia hosted ten seminars for counselors and physicians,
- a conference with experts from France, Austria, Sweden and the United States, held in Berlin on 28 October 2000,
- information brochures for women in German, Turkish, Serbo-Croat, English, French, Spanish and Russian as well as
- three small empirical surveys on the availability of medical abortion. Polls were taken among counseling centers, medical facilities and women who planned to have an abortion, respectively.

One Year after the Introduction of Mifegyne

During the first three months of 2000, 764 medical abortions with Mifegyne were conducted in Germany. That's 2.2 % of the total number of abortions. The number of medical abortions increased to 985 cases (2.9 %) in the second and to 1,186 cases (3.5 %) in the third quarter. It is striking that the number of abortions with Mifegyne is particularly low – and apparently even declining – in those cases where the expenses were covered by the States because the patients had little or no income of their own.[4] Between 1 January and 8 September 2000, the Hessian government settled a total of 2,766 abortions; only 41 of them (1.5 %) were abortions with Mifegyne. In Hesse, share of medical abortions decreased from 3 % in the first quarter to a mere 1% in the second quarter.

[4] Reimbursement according to the Act on Aid for Needy Women Having an Abortion

The fact that abortion with Mifegyne is not as common as it could be is even more remarkable as, according to the surveys that were conducted on behalf of pro familia, both physicians and counseling centers appear to be quite open-minded towards medical abortion. The surveys also show – and international studies support that view – that apparently there is a large number of women who prefer a medical method of abortion. The surveys did not indicate that either women or counseling centers or physicians in Germany have a »culturally« negative attitude towards abortion with Mifegyne.

One possible impediment for a wider distribution of medical abortion might be the fact that in Germany so far only a comparatively small number of abortions is conducted during the first couple of weeks of pregnancy (1999: 9.8% before the 8th week LMP). Also, German laws requiring an appointment with a counselor and a three days waiting period until the abortion can be conducted or the common practice to have home pregnancy tests confirmed by a doctor before a woman may be allowed to have an abortion might keep patients from choosing abortion with Mifegyne, which can only be used until the end of the 7th week LMP.

Practical experience and the surveys show, however, that the greatest obstacle is the question of reimbursement.

Reimbursement for Medical abortion

Even before Mifegyne was introduced to Germany, it was evident that for the time being there would be no satisfactory agreement on reimbursement for medical abortion. In September 1999, the joint Valuation Committee of health insurances and the Kassenaerztliche Bundesvereinigung (who represents the doctors), which lays down the compensation for medical services according to the national health care regulations, agreed to compensate physicians conducting abortions with Mifegyne with app. 100 DEM plus expenses for the medication; in November 1999, the committee decided to raise the compensation to app. 180 DEM. In comparison, a physician receives between 500 and 550 DEM for conducting surgical abortion, including local anesthesia. Also, medical abortion was included into the catalogue of benefits provided by the statutory health care system as late as 1 January 2000.

Pro familia estimates that medical abortion requires just about the same efforts as the surgical method. This conclusion is partly based on international experience and has been reported to the Valuation Committee and made public as well. The compensation defined by the valuation committee, which is far below the compensation for surgical abortion, cannot even be considered to cover the costs.

While legislation on reimbursement in cases of needy women finally passed the German parliament in December, the effort of pro familia, physicians, federal government and some state governments to reach an agreement to at least cover the costs has so far been unsuccessful.[5]

Considering this, it is no surprise that many medical facilities either do not offer

[5] The Valuation Committee is autonomous and is not subject to directions from the government. The state governments, who are responsible for reimbursement in cases of needy women, mostly follow the rates that have been defined by the Valuation Committee.

medical abortion with Mifegyne at all or do so only if the patients pay on their own. According to the study mentioned above, patients had to cover the costs by themselves in only 17 % of the cases of surgical abortion – but in 67 % of abortions with Mifegyne. Counseling centers and medical facilities report that since then the number of patients who had a medical abortion and had to cover the costs themselves has even increased. They also report that women who are legally entitled to have an abortion free of charge pay for an abortion with Mifegyne rather than undergoing surgical abortion. Pro familia is convinced that this will lead to a two-class medicine in terms of abortion.

Outlook

Virtually at the last minute, Exelgyn managed to secure the distribution of Mifegyne in Germany and to find a successor for Femagen. In spite of the high retail price of 154 DEM, the sale of Mifegyne turned into an economical loss, as the number of medical abortions was unexpectedly low and expenditures for meeting control requirements were rather high. Consequently, Femagen had decided to give up marketing rights for the drug at the end of the year 2000.

Even though Mifegyne is still available on the German market, it remains an option only for those women who can afford it – despite the fact that the women's right of free choice of methods is widely recognized in society and that there is a demand for the method. The slight increase of medical abortions between the first and third quarters of the year 2000 cannot obscure the fact that the introduction of medical abortion with Mifegyne in Germany is taking considerably longer than in France, the United Kingdom or in Sweden (cf. papers by Aubény and Oestlund in section 3).

At this time, the appropriate departments of federal government, state governments and Valuation Committee are negotiating for an acceptable compensation for physicians conducting medical abortions. It remains to be seen if these negotiations lead to results that are satisfactory.[6]

When it comes to abortion, this it not the first time that it is obvious that positive legal regulations and wide-spread acceptance in most social groups do not guarantee that the decisions of the women involved are actually respected and accepted. That is why, in spite of all the achievements we have made, we have to keep monitoring the further developments in abortion. Thus, we will be able to overcome unforeseen and unexpected obstacles.

[6] On 28 February 2001, the Valuation Committee altered the rates of compensation for medical abortion and raised the fees for supervision and care services. This decision raises the rates of compensation by a maximum of 1,000 points (app. 100 DEM).

Surveys

Surveys

among Medical Facilities, Counseling Centers and Patients on Acceptance and Availability

Targets and Methods

During the first half of the year 2000, three surveys were conducted among medical facilities, counseling centers and clients. Originally, we had planned to approach counseling centers and medical facilities together in one poll and to repeat this survey after a few months in order to be able to trace the early stages of development. As the beginning of the interviews was delayed and the time to repeat the interviews appeared to be too short, we dropped this plan. Instead, counseling centers and medical facilities were polled with different questionnaires.

All three polls were designed to be short interviews, trying to get an idea of the first experiences that were made since Mifegyne was introduced to Germany. Of course, the polls would give not more than preliminary figures and a first impression.

Medical Facilities and Counseling Centers

The poll concentrated on the following aspects:

- Do medical facilities conducting abortions offer medical abortion?
- On what basis do medical facilities decide to offer medical abortion?
- Organization of counseling, care and assistance for women having a medical abortion
- Quality of cooperation between counseling centers and facilities offering medical abortion
- Problems that, from the medical facilities' and counseling centers' points of view, arise because of the limited availability of medical abortion

In cooperation with pro familia, two 2-page questionnaires were developed. The sections concerning arguments for or against medical abortion were identical. In February 2000, questionnaires were mailed to 1,431 counseling centers and to 231 medical facilities. All of the counseling centers were certified pregnancy conflict counseling centers in Germany. The addresses of the medical facilities were provided by pro familia's state branches: i.e. 193 facilities that were known to conduct abortions. In addition, the questionnaires were sent to 46 physicians who had enrolled in seminars on Mifegyne presented by pro familia.

Clients

Reaching the women who have had a medical abortion turned out to be a difficult task. This problem was solved in two approaches: The questionnaire for medical facilities included a passage explaining the goals of interviewing the women and asking for support in distributing the questionnaires. The facilities were offered to have the samples evaluated individually for their own purposes. Also, pro familia's own medical facilities were asked for assistance. The response was encouraging, 65 % of the facilities requested a total of 1,560 questionnaires for clients.

The questionnaires for clients particularly focussed on:

- the availability of adequate information
- satisfactory counseling through counseling centers and physicians on alternative methods (before consulting the medical facility where the abortion is performed)
- satisfaction with counseling, care and assistance at the facility where abortion is carried out
- judging the method of abortion that was used (including expectations tied to both methods).

The poll was conducted after polling the medical facilities, respectively after they had requested the questionnaires. The questionnaire was designed to allow women who have had a surgical abortion to participate in the poll as well. As the procedures in both methods of abortion vary, designing the questionnaire was somewhat difficult.

Feed Back and Samples

Medical Facilities

More than 100 medical facilities participated in the survey, which is a feed back of 42 %. A little more than half of the questionnaires was returned by gynecological practices, 17 % from Belegaerzte (physicians who both operate a practice and treat patients at a hospital), 72 % from the old federal states. 46 % of the facilities had conducted medical abortions before (the majority of them, however, less than ten), 34 % planned to conduct medical abortions in the future.

Counseling Centers

Out of a total of 1,431 counseling centers, 416 replied, a response rate of 29 %, and not representative of all centers: Public operators of Bavarian counseling centers informed pro familia that they would not let the staff of their centers participate in the survey. There is reason to believe that without our knowledge further systematic distortions have occurred.

On the other hand, the feed back is quite representative concerning other criteria of evaluation:

- public operators, centers operated by churches, by pro familia and independently operated centers are fairly well represented (18 to 31 %)
- also, Western (65 %) and Eastern federal states (25 %) are represented adequately
- 40% of the questionnaires were returned from rural areas, 38 % from urban and 19 % from metropolitan areas

Although the data are in some aspects not as representative as desired, the dispersion

is large enough to reach some reliability. Besides, it is worth considering that the study is not based on samples but is a full survey. In that case, a response rate of just under 30 % is quite remarkable.

At the time of the survey, 73 % of the centers were already offering counseling on medical abortion.

Clients

In the beginning, feedback from women who had an abortion came in very slowly. Early in May only 42 women had submitted their questionnaires, 30 of whom had used Mifegyne. In order to be able to make comparisons, the centers had been asked to distribute some of the questionnaires to women who had a surgical abortion. Specific measures conducted by pro familia to raise motivation among the medical facilities eventually increased the feedback. However, this caused a considerable shift towards surgical abortions. Until mid-July a total of 181 questionnaires indicated the following weighting:

68 questionnaires from women with medical abortion
74 questionnaires from women with surgical abortion (local anesthesia)
39 questionnaires from women with surgical abortion (general anesthesia)

The response rate allows no conclusions, as the medical centers were asked to distribute the questionnaire to women who had a medical abortion, yet the total number of these abortions is unknown. However, figures published by the Federal Statistics Agency (nationwide 764 medical abortions in the first and 985 in the second quarter of 2000) indicate that only few abortions were conducted with Mifegyne. With data from only 60 medical facilities, more feed back could hardly be expected.

Surveys among Counseling Centers and Medical Facilities

As the questionnaires for medical facilities and counseling centers were in part identical, the results of both surveys will be presented together.

Views on Medical abortion

Both types of institutions were asked to state fundamental arguments for or against medical abortion (regardless if they conduct medical abortions or not).

Figure 1 shows a number of possible arguments for medical abortion; the figures for medical facilities and counseling centers are shown separately. For both, the most important argument for medical abortion is that women should have the right of free choice and that they have to decide for themselves. Remarkably, the argument of avoiding surgery or anesthesia is more important in counseling centers than in medical facilities. Both unanimously agree that the fact that medical abortion can be conducted at an early stage of pregnancy is an argument for that method. However, the argument that medical abortion is a more natural alternative for the women because it comes closer to menstruation doesn't play such an important role for either of them.

Reasons for Medical Abortion

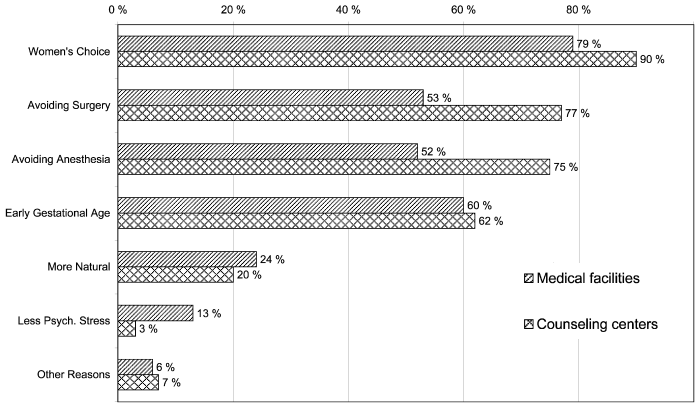

Figure 1

The degree of psychological stress for the women is rarely used as an argument for the medical method. Actually, a large faction (46 % and 42 %) believe that this is an argument against medical abortion (cf. fig. 2). Other important aspects against medical abortion are complex procedures (app. 60 % each) and more extensive care. Approximately 40 % of both groups believe that possible side effects are a negative aspect. From the medical facilities' point of view, the most important argument against medical abortion is inadequate compensation through health insurance and the federal states (64 % compared to 40 % of the counseling centers). Also, considerably more medical facilities than counseling centers consider the extensive need for care to be a negative aspect of medical abortion.

Reasons against Medical Abortion

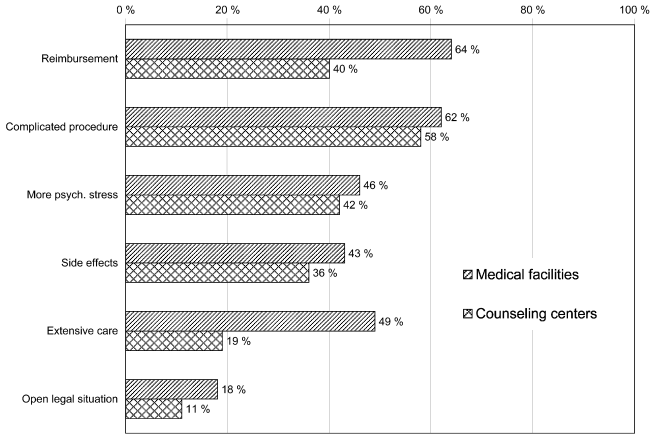

Figure 2

On average, counseling centers specify more reasons for medical abortion than against it (3.4 compared to 2.2). The data from medical centers are balanced (3.0 and 2.9), which can be explained by the more important role the issues of compensation and extensive care play on the contra side, while on the pro side avoiding anesthesia and surgery are less relevant. A closer look at those medical facilities having had experience with medical abortions before the time of the poll is quite interesting: compensation is even more (74 %), extensive care less (37 %) an argument against medical abortion.

Information and Availability

Varying views on medical abortions between counseling centers and medical facilities are probably due to an information problem: almost 50 % of the counseling centers have a »high« (43 %) and »very high« (5 %) need for courses on Mifegyne. Only 8 % do not want more information (cf. fig. 3).

Counseling Centers: Demand for Training on Medical Abortion

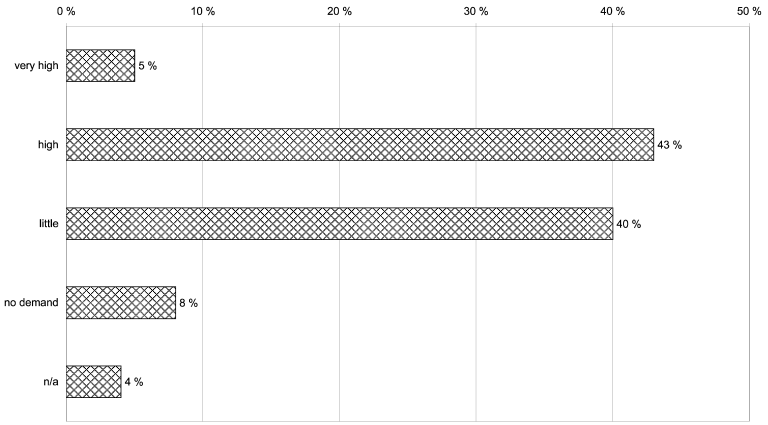

Figure 3

Information can also be passed on in either direction using contacts between medical facilities and counseling centers on a regional level. That is why both questionnaires included items on familiarity with the practice in the respective other institution:

counseling centers

»How familiar are you with the way medical abortions are practiced in your area?«

medical facilities

»How familiar are you with the way counseling according Section 219 Penal Code (Abortion Counseling Act) is practiced in those counseling centers in your area that your patients have consulted most?«

Both questions were to be answered on a scale 1 – 6 (1 being »very familiar«). Although both questions stress different aspects, the results are shown together in Figure 4.

Level of Information on Practice of Counselling / Abortion

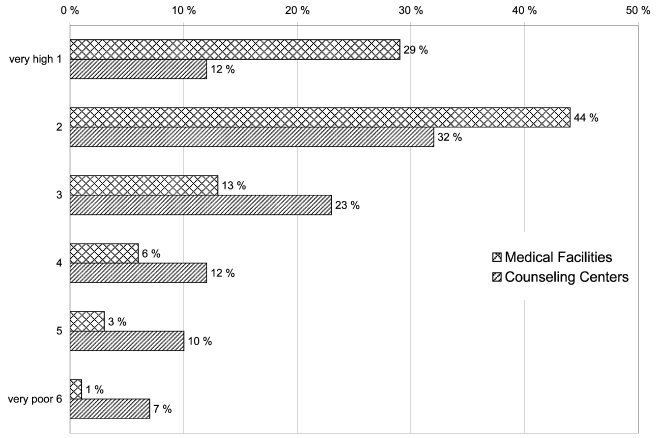

Figure 4

Medical facilities clearly state a better level of information on counseling centers than counseling centers do in reference to the practice of medical abortion. This makes sense, as patients usually consult a counseling center first, so medical facilities learn from the patients about their experience with counseling. Disregarding this difference, counseling centers show an amazingly poor level of information: less than half of them felt »very well« or »well« informed. Still, there are two aspects that might qualify these data:

- At the time of the survey, shortly after the introduction of Mifegyne, maybe there was not enough information available.
- At the same time, the actual availability of medical abortion in the area where the respective counseling centers are located may still have been poor.

The first aspect cannot be verified easily as the questionnaires were returned over a longer period of time (between February and June), which means they were not filled out at the same time. Indeed, the accounts became more differentiated in the course of time.

The second aspect could be verified directly because one item directly aimed at the regional availability of medical abortion. Figure 5 indicates that only one third of the counseling centers characterize the regional facilities as »adequate«, 44 % as »inadequate«, 16 % of the counseling centers claim that, to their knowledge, there is no medical abortion available in their area. The rate of adequate facilities increases from only 28 % in rural areas and 37 % in urban areas to 44 % in metropolitan areas.

Counseling Centers: Local Availability of Medical Abortion

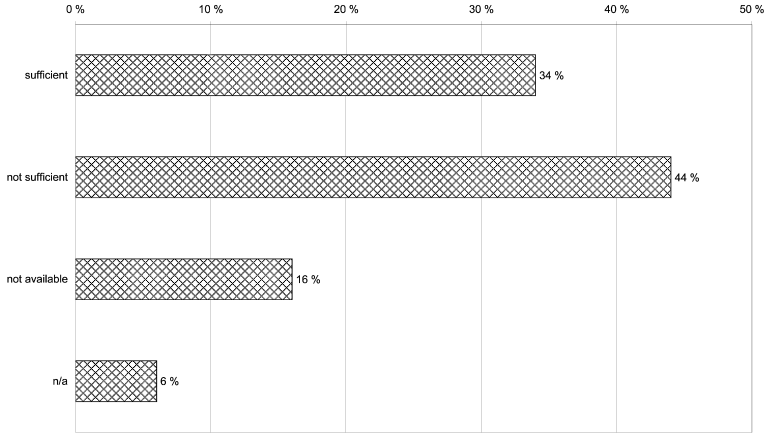

Figure 5

Medical abortion and Abortion Counseling

The counseling centers were asked to specify the contents of their counseling according Section 219 Penal Code (Abortion Counseling Act). Those not (yet) offering counseling on medical abortion were asked to state the reasons.

One quarter of the counseling centers did not offer counseling on medical abortion (yet). The reasons they stated concentrated on the following:

- 69 % had no demand for counseling on medical abortion at the time of the poll
- 34 % said they needed more information in order to provide competent counseling
- 33 % had no facilities for medical abortion in their area
- 13 % refuse to offer counseling, claiming that this is part of the doctor's responsibilities.

Restrictions imposed by the operators of the centers or rejection of the method as such were irrelevant.

At the time of the survey, 75 % of the centers did already offer counseling on Mifegyne. The figures show that almost all of them offer a wide spectrum of information:

- 96 % on procedures and time-limits
- 94 % on psychological aspects of medical abortion
- 86 % on medical facilities conducting medical abortion
- 79 % on medical issues, the way the medication works
- 74 % on the cost of medical abortion.

Only a few clients actually expressed their need for counseling and asked for it on their own initiative. On average, the centers estimate that less than 10 % of their clients consult them on their own initiative. 80 % of the centers say that the rate is below 20 %.

The medical facilities were asked to characterize the quality of the advisory services offered by the counseling centers: »What is your opinion on the quality of advice that counseling centers offer women seeking medical abortion during the compulsory consultations on the choice of methods?« At this point, it makes sense to focus only the data from medical facilities having experience with medical abortion (half of the facilities having no experience did not comment on this question). Figure 6 shows that this judgement is somewhat reserved: 45 % call the quality (very) good, 30 % call it »acceptable«. A total of 18 % say the quality is »less than acceptable« or »poor«.

Quality of Conseling According to Section 219 Penal Code from Medical Facilities' Perspective

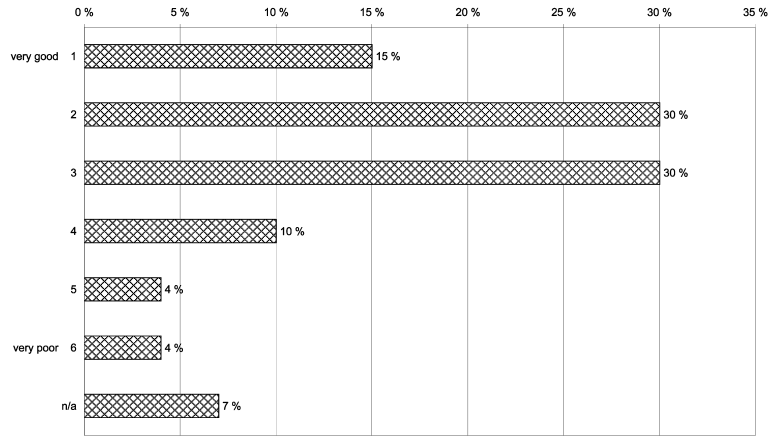

Figure 6

Survey among Patients

The evaluation is based on samples from 68 women having had medical abortion and 113 women having had surgical abortion (39 with general anesthesia, 74 with local anesthesia). One important result of the survey is that many facilities do not offer medical abortion at all, while others are reluctant to offer this method.

The data are presented in a way that allows comparisons between the medical and the surgical method. However, the reader has to bear in mind that 90 % of the surgical abortions and only 20 % of the medical ones were conducted in medical facilities operated by pro familia. Almost 60 % of the abortions with Mifegyne were carried out at practices of gynecologists. This is a systematic distortion of the survey and should be taken in account as the data are interpreted.

Reasons why Patients Opt for Either Method of Abortion

The questionnaire featured 12 possible reasons, the interviewees could check more than one item. Also, the patients were asked to state the most important reason for their decisions.

Figure 7 shows the spectrum of reasons. In most cases both women who had a medical abortion and the ones who chose the surgical method said that, »getting over with it fast« was the reason to opt for one or the other method. At least for the Mifegyne patients, the point of time the abortion was carried out was another important aspect. Women, who had a surgical abortion and wanted »to get over with it fast«, probably refer to the abortion procedure itself. On the other hand, patients of medical abortion were likely to interpret this item in the sense of having this method of abortion at a very early stage of pregnancy, presenting an entirely different understanding of the same item.

Reasons to Choose either one Method

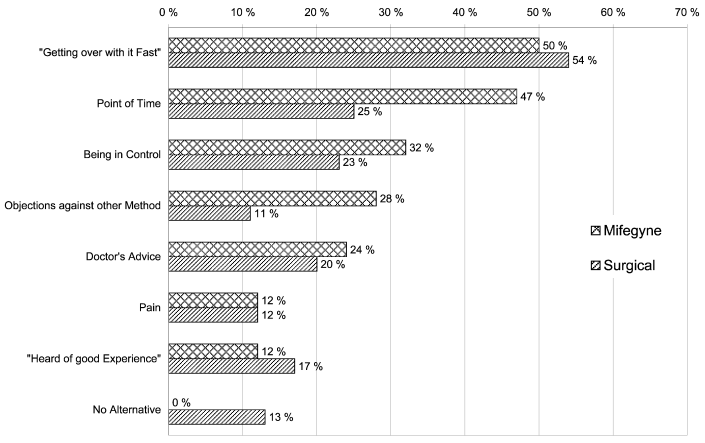

Figure 7

Fundamental reservations were mostly stated by the users of Mifegyne: They preferred medical abortion to the surgical method.

Naturally, good experience other women may have had with their abortion plays a less important role for Mifegyne patients than for those who chose the surgical method as the drug hasn't been on the market long enough. The answer »no other choice« was given only by women who had a surgical abortion.

When asked to state the most important reason to decide in favor of one of the methods (Figure 8), again most women said they wanted »to get over with it fast«. The aspect of time apparently matters particularly to patients who had a medical abortion, as they call the item »abortion at an early stage of pregnancy« the second-most important reason for their choice. In these cases, both answers have to be considered as complementary.

Concerning surgical abortions, the time of abortion plays only a minor role (which means in this case that often, medical abortion cannot be conducted after the seventh week). But there is a flaw in the design of the questionnaire that does play a role: Patients past the seventh week, who can no longer use Mifegyne, still have the choice between different methods of anesthesia. Thus, they name a different »most important« reason for their decision.

Most Important Reason for Choice

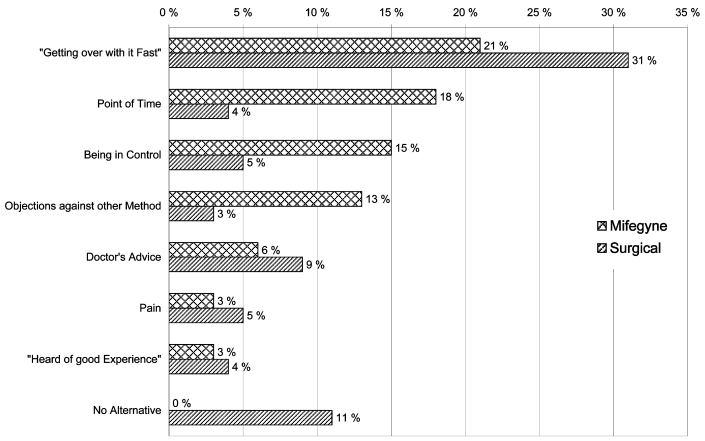

Figure 8

Understandibly enough, to patients choosing the medical method »being in control« is a much more important aspect.

Reservations towards the other method (no chemicals – no surgery) are rarely an issue for those women who chose the surgical method. In comparison, avoiding surgery ranked fourth among Mifegyne patients. Decisive for 11 % of the women choosing the surgical method was the fact that medical abortion was not available.

Personal positive or negative experience or experience of others played only a minor role and were not included in the chart.

The women were asked to rate counseling prior to the abortion, assistance and care

during abortion as well as the second appointment at the doctor's office/in the hospital (medical abortion only) on a scale ranging from 1 (very good) to 6 (poor). All together, these ratings were extremely good. The average is »very good« or »good«. Varying ratings between surgical and medical methods have little relevance. The data in Figures 9 to 11 are based on those women who stated that counseling and care were »very good«.

Rating of Counseling before Abortion

Ratings »very good«

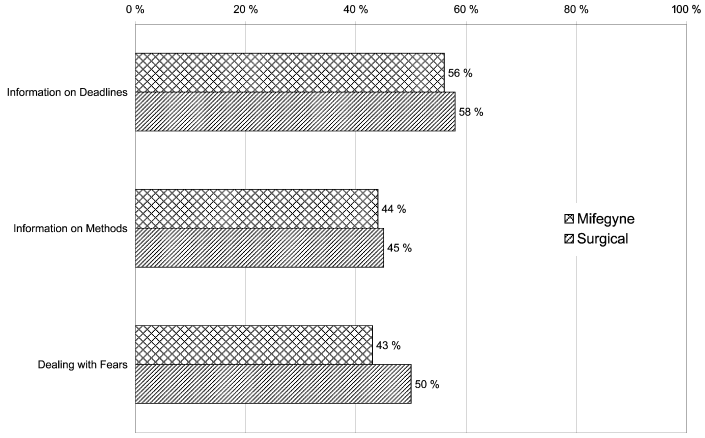

Figure 9

Rating of Counseling and Care during Abortion

Ratings »very good«

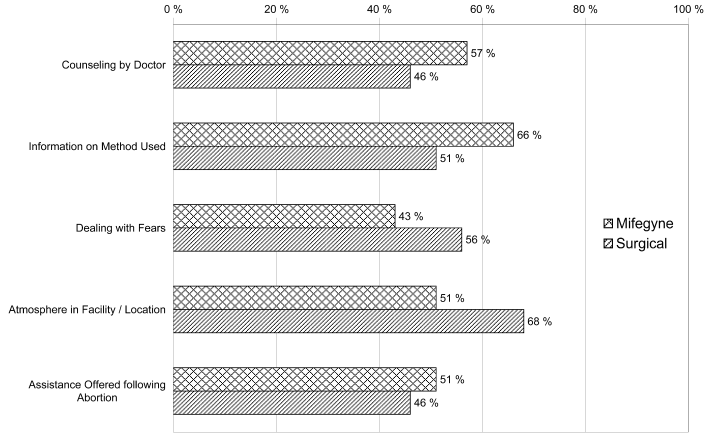

Figure 10

Rating of 2nd Appointment at Medical Facility (Prostaglandin, Mifegyne Patients Only)

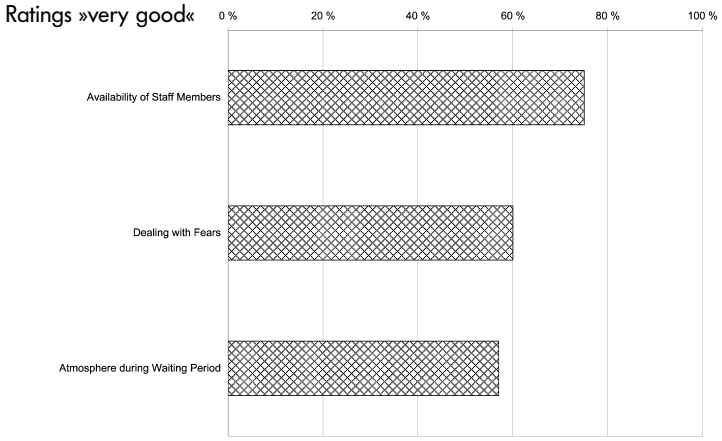

Figure 11

Remarkably often, both Mifegyne patients and surgery patients, rated counseling and care »very good«. Rating pre-abortion counseling, both groups largely agree. However, there are differences in the way the women judge counseling and care during the abortion: Mifegyne patients are considerably more satisfied with the information given on the methods available as well as on the method they eventually choose. Women who have opted for the surgical method, on the other hand, are more likely to rate the way the staff would deal with their fears, their insecurity, their desires, and the atmosphere at the facility as such better than Mifegyne patients do.

In this interpretation, there are two aspects we need to keep in mind. Information for Mifegyne patients on alternative methods is probably more extensive

- because, in those cases where women are preparing for surgical abortion, they usually are past the seventh week. They no longer qualify for the medical method.
- because, facilities that do not offer the medical method in the first place are not likely to offer information on this method.

It is noteworthy that almost all patients with surgical abortion – who give higher rating to the atmosphere during the treatment as well as to the way their fears were dealt with than Mifegyne patients do – were treated in facilities operated by pro familia. The sample is too small for a more detailed analysis.

The financial burden caused by the method that was chosen varies considerably: The women were asked »Did you cover the expenses of the abortion yourself?«. Two thirds of the women who underwent surgery stated that they had been fully reimbursed (based on the Act on Aid for Needy Women Having an Abortion or based on medical or other legal reasons causing a claim for reimbursement). In comparison, only 40 % of the Mifegyne patients were fully reimbursed. More than half of the Mifegyne patients paid for the treatment themselves (cf. Figure 12).

Payment for Abortion

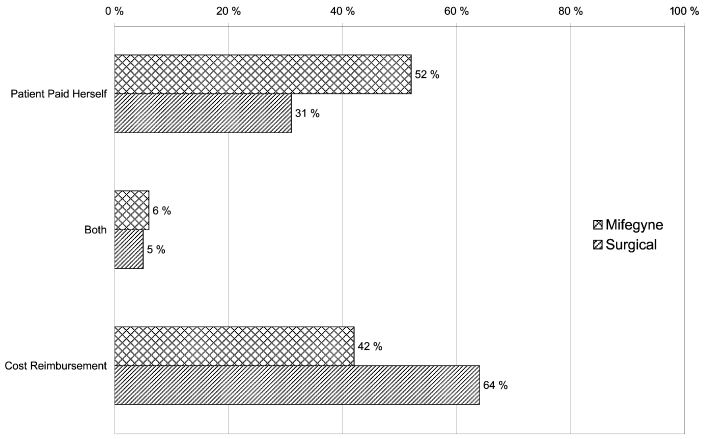

Figure 12

In order to find out more on the procedure of abortion itself, the women were asked: »In both methods of abortion, there is a course of events that doctors observe in most cases and that they call the 'normal course of events'. What did you experience? Did you have a 'normal' abortion?« The results are shown in Figure 13. On account of the size of the sample, these figures can only be interpreted to the effect that there are no striking differences between the two methods of abortion.

Course of Abortion According to Doctor's View

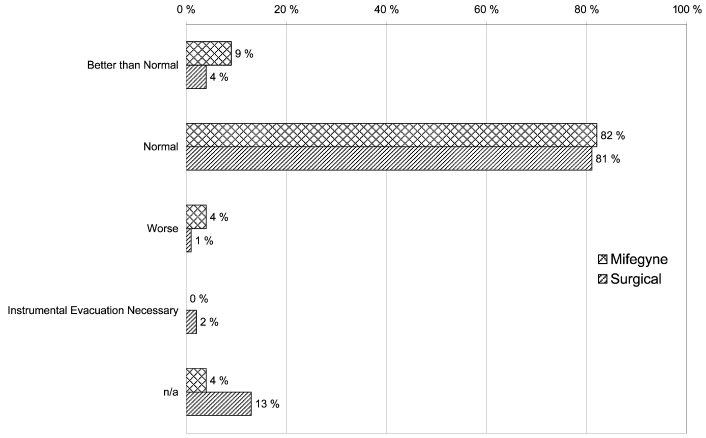

Figure 13

At the end of the questionnaire, the women were asked to rate their satisfaction with a number of aspects concerning their abortion and to compare them with their expectations/fears prior to the treatment. Here, too, the results were extremely positive. Again, Figure 14 shows the »extremely satisfied« ratings only, which allows a closer look at the ratings. In most of the aspects stated in this question, more than 90 % of the interviewees said they were »satisfied« or »very satisfied«, which is another important result from this survey.

»Very Satisfied« Looking Back at Expectations/Fears

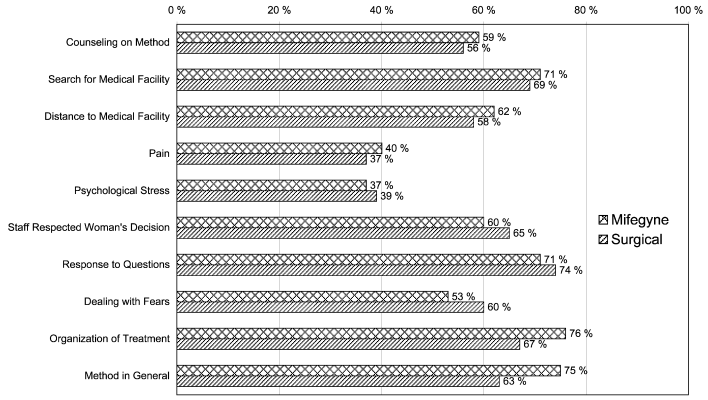

Figure 14

There is another striking discovery shown in Figure 14: Apparently, the extent of psychological strain and physical pain have been underestimated in the past. Also, there is a higher proportion of Mifegyne patients being »very satisfied« with the overall organization of the treatment and with the method as such – although the procedure is more complicated than surgery. An explanation for this phenomenon cannot be deduced from the other items because there are few differences. But it can probably explained by those aspects that played an important role when the patient decided to have a medical abortion: the early stage of pregnancy and the sense of being in control.

Summary

In general, both counseling centers and medical facilities have a positive attitude towards medical abortion. The most important aspect is that women have an extra option. First experience with that method has shown that some counter-arguments (extensive care, complicated procedure) are less relevant. Inadequate reimbursement and compensation, however, are the main arguments against medical abortion. Inadequate compensation, on the one hand, is the reason why this method is rarely

offered or is offered only by a few medical facilities. On the other hand, inadequate reimbursement is the reason why there are considerably more Mifegyne patients having to cover the expenses on their own than women choosing surgical abortion.

Counseling centers say that the demand for training and seminars on the medical method is still high. The centers have little information on how the medical method is conducted and where in their area it is available. This is due to the fact that 80 % of the counseling centers do not have facilities conducting medical abortion in their area.

Women choosing medical abortion do so because they can have the procedure at an early stage of pregnancy and because they stay in control as much as possible. Also, they are uncomfortable with the idea of having surgery.

Satisfaction with all aspects of counseling and treatment is very high among the women participating in the survey. Most fears prior to the abortion are not realized finally. As there are no comparative figures, it cannot be determined if this is simply due to the sample or if this is truly a reflection of the situation in Germany. It should also be taken in account that the women participating in the survey were recruited from a rather small number of medical facilities.

Conference

Conference

on Medical abortion with Mifegyne

Berlin, 28 October 2000

Program

Date: 28th October 2000

Initiated by pro familia German Society for Family Planning, Sexual Education and Counseling, Stresemannallee 3, 60596 Frankfurt am Main
Location: Goethe-Institut, Neue Schoenhauser Strasse 20, Berlin, Germany

9:30 am	Opening Address Elke Thoss, Executive Director, pro familia, Frankfurt am Main, Germany
	Address Dr. Christine Bergmann, Federal Minister for Family, Senior Citizens, Women and Youth, Berlin, Germany
	Introduction Dr. Ulrike Busch, pro familia / Balance Family Planning Clinic, Berlin, Germany
10:00 am	I. Medical Standards in Medical abortion with Mifegyne Medical Standards in France Dr. Elisabeth Aubény, Hôpital Broussais, Paris, France Medical Standards in Sweden Dr. Ingrid Oestlund, Orebroll, Sweden
10:30 am	Discussion hosted by Gundel Koebke
10:45 am	II. Care Standards in Medical abortion with Mifegyne International Care Standards Dr. Christian Fiala, General Hospital Korneuburg/Vienna, Austria Experiences and Problems from the German Perspective Elfie Mayer, Family Planning Clinic, Hamburg, Germany
11:15 am	Discussion
11:30 am	Coffee Break
11:45 am	III. Qualifications for Medical abortion with Mifegyne International Standards of Qualification Dr. Beverly Winikoff, Population Council, New York, NY, USA Latest Developments and Problems in Training and Further Education in the Field of Abortion Prof. Dr. Hans-Georg Siedentopf, formerly Director Outpatients' Dpt. Universitaetsfrauenklinik Frankfurt am Main, Germany
12:15 pm	Discussion

12:30 pm	IV. Availability and Reimbursement of Medical Care in connection with Medical abortion with Mifegyne Empirical Data on Medical abortion in Germany Klaus Riemann, Gesomed Society for Sociological Research in Medicine, Freiburg, Germany Costs and Reimbursement through Health Insurance and Federal States Hanna Staudt-Hupke, Executive Director, pro familia Bremen, Germany
1:00 pm	Discussion
1:30 pm	Lunch Break
3:00 pm	Workshops (1) Medical Standards hosted by Dr. Gabriele Halder, Berlin, Germany (2) Care Standards hosted by Elfie Mayer, Hamburg, Germany (3) Costs/ Reimbursement hosted by Hanna Staudt-Hupke, Bremen, Germany (4) Training and further Education hosted by Dr. Ansgar Pett, Berlin, Germany
4:30 pm	Results from Workshops / Discussion
5:55 pm	Closing Remarks Elke Thoss, Executive Director, pro familia, Frankfurt am Main, Germany
6:00 pm	End

Opening Address

Elke Thoss, Executive Director pro familia, Frankfurt am Main

I would like to welcome you to the pro familia conference on Medical abortion with Mifegyne. »For Free Choice and for Internationally Accepted Standards« – that is the motto pro familia has chosen for this conference.

One year ago, the drug Mifegyne was certified for medical abortion in Germany. At last, we thought women in this country have the choice if they want a medical or a surgical abortion. This choice is bound to turn into a farce. We think that women's right of free choice is not taken seriously. And nobody wants to pay for it. For months, a struggle to fund medical abortion has been going on. Due to the regulations of compensation, at this time we cannot even offer treatment that is cost-effective. And now, also because of financial reasons, the Femagen company has decided to take the drug off the market. It looks like the introduction of Mifegyne to Germany has failed. You all have heard the bad news.

It's the good news we are expecting from this conference. Already now, I have some good news for you: This conference would not have been possible without the financial support of the Federal Ministry for Family, Senior Citizens, Women and Youth. On behalf of pro familia, I would like to thank you very much, dear Madam Minister Bergmann, for this support. The fact that you are attending this conference shows your commitment in spite of all the difficulties we are facing in connection with the introduction of Mifegyne. Also, we are happy to welcome a representative of the Brandenburg State Ministry for Labor, Social Affairs, Health and Women. Under the administration of Regine Hildebrandt, long before Mifegyne was actually certified, this Ministry actively advocated this certification. Also, I would like to welcome representatives of the German Bundestag.

Our international guests will share with us their scientific findings and their experience. They will give us access to international standards on medical abortion. Finally, I would like to welcome a number of experts, among them many specialists of pro familia. They, too, contribute to this conference with their know-how and their experience.

From this conference, pro familia is expecting an exchange of ideas and encouragement that can help prevent Germany from falling back to the state of a developing country as far as the women's right of free choice is concerned. I assure you that pro familia will not stop advocating women's free choice. Along these lines, I wish all of us a successful conference.

Address

Dr. Christine Bergmann, Federal Minister for Family, Senior Citizens, Women and Youth

Ladies and gentlemen,

We had planned to take stock at today's conference, one year after the introduction of Mifegyne: What experience have we had? What are the problems? What can we do to help Mifegyne getting the status it deserves? Now, a debate on Mifegyne's future is casting a shadow on this conference. That is to say, it is not clear if Mifegyne will be available as an alternative much longer.

It has been a long ideological struggle until last November when Mifegyne first became available in this country. Being a pharmacist myself – I didn't become a politician until I was 50 years old – I don't know of any other case where it took a change of government to have a drug certified. When we took office we made a clear political commitment for this alternative method of abortion.

After the drug was certified we believed that the introduction of Mifegyne was accomplished. But looking at the number of medical abortions we have to realize that during the first quarter of the year 2000 a mere 764 and in the second quarter 985 medical abortions were conducted. That is two to three per cent of the total number of abortions. The number of abortions with Mifegyne was even smaller in cases where the states were to reimburse the costs to those patients with little or no income. Depending on the state, the rate was between zero and 1.5 per cent.

Now, you could argue that new methods need time to be generally accepted. But this cannot be the only reason for these low figures. From a survey among physicians we know that inadequate compensation for the treatment with Mifegyne is an important reason why this method is rarely used. The drug and the medical care involved in this treatment have been classified too low.

We want this medical alternative to surgery. We want women to have the choice. There is no reason to deny this alternative to women. In other areas of medicine, this would not be possible, either.

The Valuation Committee, consisting equally of representatives of the Kassenaerztliche Bundesvereinigung (Federal Association of Physicians under the statutory health insurance scheme) and the Spitzenverbaende der Krankenkassen (central organizations of statutory health insurance) has classified medical abortion without considering certain issues. We have data and figures clearly confirming that. In the last months, we – along with the Federal Ministry of Health – talked again and again with the Committee on this issue. So far, however, the Valuation Committee is not willing to agree to an adequate settlement. We will not put up with that. Cost-effective compensation is the most sensible way to establish abortion with Mifegyne as an alternative. That is why we will continue our work on the Committee's attitude.

We have set clear legal regulations. According to section 13 of the Act on Pregnancy Conflict, medical facilities carrying out abortions have to be able to act when complications occur. Our main argument is that cost reimbursement must reflect these regulations. That is another reason why we cannot put up with the Valuation Committee's classification. After all, we are not the only ones to call for modification: The States'

conferences of Health Ministers and Ministers for Women have articulated this call just as clearly. What else does it take to make it plain that the classification has to be revised?

I do not believe that we can solve the problem by changing the way the drug is distributed. After all, pharmacies and wholesales have their profit margins, too. We have regulated the ways of distribution after detailed hearings; after two years, they will be subject to reconsideration.

There are more ideas about how to make the introduction of Mifegyne easier. We are considering a revision of the Act on Assistance for Pregnant Women, the Health Insurance Code. In addition to changing the Committee's mind, we will take all possibilities in account. Using all our legal options, however, may result in the problem of causing inconsistent regulations on the state level. Already today, there are federal states, like Schleswig-Holstein or Baden-Wuerttemberg, that go beyond the classification and have made their own settlements with the health insurance system. Standard regulations on which women in all German states can rely would be a better solution.

There is also the problem that on the legal level we can only regulate those issues that are subject to the Counseling Act and not those related to abortions indicated for certain legal reasons. That is why I would like to assure you that, apart from all our efforts to find alternative regulations, it is our primary goal to prompt the Committee to agree to a sensible classification and to establish a standard in all states.

At today's conference we will hear about the situation in other countries. That will help us discuss this issue. In Germany, we are approaching this issue in a very ideological manner. Many other European countries don't seem to do that. Even in the US, certification of the drug Mifegyne has been approved by the highest authorities. In order to discuss medical abortion in Germany in an unbiased way, it is important to show how other countries deal with this issue and what they have accomplished. We want to show what this alternative method means to women.

May this conference be a successful one and may its results be known everywhere.

Introduction

Dr. Ulrike Busch, Executive Director of Balance Family Planning Clinic, Berlin

The history of medical abortion in Germany is a story of conflict and impediments. This is no surprise as abortion is a highly controversial issue. More than a decade ago, pro familia initiated the first conference on RU 486. Back then, it dealt with the results that research had provided so far as well as the prospects of this new method. Meanwhile, the drug has been registered in Germany for more than a year and has been available for almost as long. The road for this alternative method of pregnancy termination is open and yet it is not. The small number of medical abortions compared to the total number of abortions speaks for itself. This conference is dedicated to give this issue new momentum.

1. Professional level: Talks with doctors as well reports from women and counselors show that several doctors still feel they need to know more about this method. Still, there are concerns about the use of Cytotec; apparently, the Deutsche Gesellschaft fuer Gynaekologie und Geburtshilfe's (German Society for Gynecology and Obstetrics) demand for prohibition of abortion if the pregnancy is not provably viable has still not been ruled out; there are still concerns that this method of abortion is physically and emotionally an unreasonable burden for the women. Also, it has yet to be determined how much care the patients actually need.

German experiences have to be linked with international ones, medical as well as care standards need to be discussed and defined; recommendations for training and qualification need to be developed.

2. Political level: The small number of medical abortions compared to the number of abortions in general is due to the inadequate rates of reimbursement that most Federal States provide to those women who are eligible. The Federal States feel bound by the regulations issued by the Valuation Committee of the Kassenaerztliche Bundesvereinigung and the health insurances. So far, the Valuation Committee is not ready to reconsider regulation standards. Thus, this modern method of abortion is de facto not available for some 70 % of those women who are eligible for reimbursement and will be all together unavailable if the marketing company Femagen retreats from the market.

A method that belongs into the hands of women, that increases the options they can choose from and improves their self-awareness requires strong support. The objective of this conference is to develop professionally and politically founded demands and to address them to all responsible parties, to lobbies and to the public.

For years, pro familia has been committed to the cause of medical abortion – not because an abortion with Mifegyne is the most gentle method but because women should have the opportunity to choose the method that is the most suitable for themselves. Pro familia is also very much committed to work on those problems that haven't been solved yet. The main points of the conference reflect the issues that are still not settled. On behalf of the women affected by the issue of abortion, we want this conference to move the discussion forward.

Papers

I. Medical Standards

Medical Abortion in France with Mifepristone and Misoprostol

Dr. Elisabeth Aubény, France

The method presently used in France was introduced to the French market in 1992 and to the European market in 1999. In France, 600,000 women have used this method without any major complications. It may be used up to 49 days LMP:

Day 1: Mifepristone (600mg, 3 tablets), administered at an authorized medical center.

Day 3 / 48 hrs. later: Misoprostol (Cytotec®) 400µg, administered at an authorized medical center; afterwards 3 hours of supervision at the medical center.

10-14 days later: check up at the medical center.

As French law prescribes a time for reflection before an abortion may be conducted, the women need to see or speak with a counselor 8 days before taking Mifepristone.

Results

First of all a definition: if the fetus is expelled without any surgical intervention, the medical abortion is successful. If surgical intervention becomes necessary, the medical abortion has failed. 95.4 % of the abortions have been successful in one study. In 4,6 % of the cases the method has failed. The percentage of failures can be broken down as follows: Pregnancy ongoing in 1.5 % of the cases, incomplete expulsion of the fetus: 2.8 %, curettage to stop haemorrhage: 3 % (R. Peyron, A. Ulmann. Presse Médicale 95).

In order to make the treatment more effective, one variant on this method (Broussais Method) is frequently used: if the fetus is not expelled within 3 hours, the patient is treated with a second dose of misoprostol 400µg. The rate of successful abortions increases to 98.5 % which makes the medical method just as reliable as the suction method.

Details

In 39 % of the cases, the fetus is expelled after the patient has left the hospital. This occurs in 2.2 % of the cases before treatment with misoprostol. In 61 % of the cases, the fetus is expelled during the 3 hour period of supervision at the medical center. On average, bleeding lasts up to 9 days. Surgery to stop bleeding is necessary in 0.3 %, a blood transfusion in 0.1 % of the cases.

Side Effects

Abdominal Pain: 20 % of the patients do not feel any pain at all. 60 % experience pain but do not need to be treated for it and 20 % of the patient do need mild pain relief.

Often, the digestive system is affected (42.8 % suffer from nausea) but in most cases, special treatment is not necessary.

Mifepristone 600mg + misoprostol 400µg is an effective, safe and easy to use method up to 49 days LMP.

During an experiment to improve the method, the treatment was conducted up to the 63rd day LMP. Since the number of failures and bleeding increased, medical abortion is no longer used after the 49th day.

Note: Experiences during the past 7 years have shown that misoprostol preferably should be taken at home. The drug is very well tolerated and does not require special medical supervision.

Medical Method in comparison to Surgical Method

1. Medical Level

- Efficacy and safety are comparable.
- Post-abortion bleeding lasts longer after using mifepristone but is not greater overall than after a surgical abortion.
- An abortion with mifepristone leaves the womb intact. Unlike the surgical method, there is no risk of perforation.

2. Acceptability

The surgical method is faster but it requires the woman to be in an operating room and it requires anesthesia. Many women consider this an unreasonable burden.

The Mifepristone Method is chosen by women who argue that it

- avoids surgery and anesthesia which they experience as being aggressive
- is more natural
- is less »medicalized«: it is the women who take responsibility and not the doctor
- allows them more intimacy: they don't have to expose themselves, their sense of privacy is respected
- does not involve intrusion into the genital area.

The fact that the number of medical abortions in France has increased compared to the total number of abortions (which remained steady) is clear evidence that the method enjoys wide acceptance. It rose from 14 % in 1990 (Droit des Femmes) to 30 % in 1999 (Exelgyn).

Summary

Medical abortion with mifepristone 600 mg + misoprostol 400µg is an effective and safe method until the 49th day LMP. However, it requires the patient's active cooperation. In general, women prefer this method if the choice is left to them.

When it comes to abortion, mifepristone
- is a new option for women
- must be made available to them in the difficult situation that a voluntary abortion always is.

»It is their moral property.«

Medical abortion – the Standard in Sweden

Dr. Ingrid Oestlund, Sweden

In Sweden medical abortion as termination of first trimester pregnancy was introduced in late 1992. At that time, medical abortion was available only in France and Great Britain. There were a lot of studies showing effectiveness up to 63 days LMP when using mifepristone 600 mg in combination with Gemeprost 1 mg vaginally, and this was also the standard in the application in Sweden. Several studies were also carried out in Sweden, especially at the WHO-collaborating center at Karolinska Hospital in Stockholm. Knowledge of the method was rather widespread within the country among gynecologists.

In the early 90s, economic considerations were quite important. Many departments all over the country hesitated to implement medical abortion because of the costs of the medication. Others, as my own clinic, focused the advantages for the woman. The clinics that really seriously implemented the method soon found out that there was a lot of doctor's time to save. Studies have also shown great satisfaction among women when they can choose their method of abortion.

Nowadays, medical abortion is available all over the country, and about 50 % of all early terminations of pregnancy are drug-induced abortions. Although the medical standard in Sweden is mifepristone 600mg and Gemeprost 1 mg, many clinics have used mifepristone in combination with misoprostol in different doses and administrations, both oral and vaginally. Sadly, this has been going on without any protocol, so we really don't know the results of those clinical routines. Many clinicians have not been aware of the characteristics of the different prostaglandines and the importance of gestational age - that is, if you do a drug induced abortion over 49 days LMP, 400 μg of misoprostol is not enough. The experience of introducing a new method where there is a well-established alternative – that is, the surgical procedure – is that you should be a good organizer and learn from others, wanting to work with other health professionals. For medical abortion services it is necessary to develop strategies to deal with pain as well as an effective follow-up visit schedule.

Mifepristone has been registered for routine clinical use in Sweden since 1994 for termination of second trimester pregnancy together with Gemeprost. Soon after registration, this became the standard method all over the country. Recently, a report in Acta Obstet & Gynecol Scand shows the clinical experience of 197 consecutive cases during the period 1996-98 at Karolinska Hospital in Stockholm; the median time to abortion was 9.0 hours for primigravidae and 7.2 hours for multigravidae. Except for one case of heavy bleeding, there were no serious complications. The authors conclude that this study confirms the efficacy and safety of mifepristone, together with Gemeprost, for termination of second trimester pregnancy when used routinely in the clinic.

II. Care Standards

Counseling before and Assistance during Abortions with Mifegyne

Dr. Christian Fiala, Austria

Counseling for women with unwanted pregnancies who are considering abortion will not have to be revised just because of Mifegyne. However, once a decision has been made to actually use this method, women will need additional consultation and care during treatment. Women deserve thorough information and advice, so they can decide for themselves what method of abortion is best for them. After all, they have to choose from among three methods that they usually are not acquainted with.

Apart from this, there is a fairly rigid framework of legal and medical regulations which at times appears to be arbitrary and doesn't always meet women's actual needs.

Differences from Surgical Abortion

Surgical abortion is a single act where the physician plays a crucial role. In contrast, medical abortion is a process going on for several days. Here, the woman remains in charge. She is actively involved in the treatment and experiences the abortion consciously. Thus, she has the opportunity to reconsider her often quite negative feelings towards an abortion. The experience of expelling the amniotic sac is crucial. In most cases it is obvious now that a »child« has not yet developed. In addition, the woman will be able to withdraw from pregnancy in an active way and to cope with the situation as such. Thus, it is no surprise that after treatment most women were relieved and amazed that the whole process unfolded so undramatically.

Compared to surgical abortion there is another difference: physicians spend less time attending their patients and there is less medical intervention. On the other hand, the relationship between the patient and the counselor plays a more important role. The continuity of this relationship during the treatment is a new aspect in this field.

Also, at the patient's request her partner might be included more intimately in the treatment.

This presentation will focus on the details during treatment and possible changes of the procedures.

Care Standards: Experience of Family Planning Clinics in Germany

Elfie Mayer, Germany

1. Best possible care according to experience with medical abortion of pregnancies gathered in German family planning clinics (particularly in Hamburg) between December 1999 and late October 2000:

- well-meaning, i. e. positive attitude of all staff members involved
- friendly, pleasant environment
- long experience with surgical abortion
- high medical standards without clinicians' bias towards abortion
- capability of various professional groups to provide all aspects of care/assistance
- short waits

2. Medical abortion between »most gentle method« and »unreasonable burden for the patient«:

- comprehensive, unbiased information on all methods of abortion
- »skills« (abilities/competence) of counselors/physicians in helping the patient to choose the most suitable method
- opportunity to choose from various methods
- to a great extent, the woman is free to decide for herself

3. Problems in providing adequate care standards in Germany and suggestions for minimum standards:

- availability in urban/rural areas
- accessibility, opening hours
- amount of time that patient and medical staff are required to spend
- meeting deadlines
- inaccurate ideas and lack of information about the method
- inadequate reimbursement / compensation
- clinics, physicians and counseling centers lack sufficient knowledge about medical abortion
- accessibility of clinics
- guidelines for rooms, staff and technical equipment (quality standards)
- equal state of knowledge, further vocational training for clinics and practices
- scientific support
- documentation of abortions
- exchange of experiences nationally and internationally.

III. Qualification

Dr. Beverly Winikoff, USA

Mifepristone (Mifegyne) has been registered in more than a dozen European countries, Russia, Israel, and the United States for termination of early first trimester pregnancy. The approval of regulatory agencies means that the drug is safe and effective for the indications registered. Experience in Europe, the United States and other parts of the world shows that this simple regimen can be provided in a wide range of health care settings with high acceptability to both patients and doctors.

Effective provision of the regimen requires a good understanding by health care providers of the special characteristics of the method. Since it is very different from surgical abortion, mifepristone abortion service providers will need to learn to think and act in ways slightly different from usual abortion providers. The most important tool for provision of this method is understanding by the physician. Doctors need to know the process of drug-induced pregnancy loss, the wide margin of safety afforded by this method, the importance of avoiding overtreatment of incomplete abortion, and the crucial importance of information and advice to patients.

Skills needed by the provider include: ability to date the age of the gestation, ability to know when to offer surgical completion of the process, ability to provide or refer to a proper source for vacuum aspiration if needed, and ability to explain the method to patients accurately and with confidence. It is not necessary to use a great deal of medical technology or to monitor patients excessively in order to provide this service safely.

This paper will provide examples of the use of medical abortion with mifepristone and misoprostol in different medical environments and show how to enhance provision of the method, maintaining patient autonomy and comfort while reducing burdens on both providers and on women. The experience of the early providers of the method in the United States will be presented, and issues such as the role of ultrasound and the possibility of use of the medications at home by women will be discussed.

Latest Developments and Problems in Training and Further Education in the Field of Abortion

Prof. Dr. med. Hans-G. Siedentopf

The history of termination of pregnancies in Germany is marked by constant political, ideological, legal and medical confrontation. The uncertainty among both counselors and doctors as well as the women involved illustrates this. Consequently, it is difficult to develop and to maintain standardized training and quality standards.

In many hospitals, abortions are conducted by interns who have not yet finished their education in gynecology. Senior physicians are consulted only when problems occur. Thus, it is often experience that is missing.

An abortion requires awareness of the fundamental (ethical) problem that termination of pregnancy constitutes on the part of all of those who are involved. In the long run, abortion cannot be conducted with routine attitude.

Conducting abortions requires regularly recurring training as well as equally regularly recurring support in case of psychological conflict and strain. Specialists are a greater help than those who carry out abortions only due to gynecological training schedule or their position in clinic hierarchy.

Different techniques of abortion and how to teach them will be discussed.

IV. Availability and Financing

Empirical Data on Medical abortion in Germany

Klaus Riemann, GESOMED, Freiburg

This presentation is based on figures from the official statistics on medical abortions and on data from three studies specifically conducted for pro familia earlier this year:

- a survey of 100 medical centers, about half of which had conducted medical abortions previously
- a survey of 420 counseling centers and
- a survey of 213 women, 89 of whom had a medical abortion with Mifegyne.

All three surveys were designed to be short and concise in order to record the first experiences after Mifegyne was introduced in Germany. From the beginning, it was clear that these studies would not be able to give more than a first impression.

Data from official statistics suggest that during the first quarter of the year 2000 no more than 800-850 medical abortions were conducted. Figures from the Federal State of Hesse imply that the number might have declined during the subsequent quarters. These assumptions are confirmed by the fact that only few of the questionnaires were actually returned: participating medical centers were provided with a total of 1,600 questionnaires, while only 89 of them were actually returned by women who had a medical abortion.

There are hardly any differences in the women's judgments on surgical and medical abortion. Both methods seem to have their supporters among women: either because of reservations towards the other method (reservations towards surgery / drugs) or because the basic conditions (time, self-determination) suggest that one method or the other is more suitable.

In principle, counseling and medical centers participating in the survey show a positive attitude towards medical abortion. The most important argument is that women have an additional option to choose from. Some of the counter-arguments (extensive care, complicated procedure) become relative after first experiences with the medical method. The most important argument against medical abortion is insufficient reimbursement. Particularly after first experiences with medical abortion, 75 % of the medical centers mention this problem.

The result is that this method is seldom offered. Only one third of the counseling centers would call the regional conditions for medical abortion »sufficient«, 44 % consider them as »not sufficient«, 16 % state that medical abortions are not offered at all in their region. Among those women who have had a medical abortion, there were considerably more (55 %) without reimbursement than among those who underwent the surgical method (30 %).

This leads to the conclusion that while there is a demand for medical abortion and while the method enjoys a positive reputation among those involved, it is hardly available anywhere because of insufficient reimbursement.

Costs and Reimbursement through Health Insurance and Federal States

Hanna Staudt-Hupke, Germany

The drug Mifegyne has been available in Germany for medical abortion of pregnancy since late 1999. Only some 2 % of women with an abortion have chosen this method, whereas in France approximately 35 % decide to use the »abortion pill«.

During the first quarter of the year 2000, there were 3,877 abortions before the 6th week from conception. That is 11 % of a total of 35,339 abortions (source: Federal Office of Statistics). Why do so few women decide in favor of medical abortion with Mifegyne?

Reasons why the medical method so far has failed to gain general acceptance

To the women the complicated legal situation (Act on Assistance for Pregnant Women and Families, section 218 Penal Code, Act on Pregnancy Conflict, Medication Act), the treatment with Mifegyne being limited to 7 weeks LMP, insufficient information and care systems add up to a race with time.

80.4 % of women choose an abortion under general anesthesia. Is this the desire for complete absence of pain, to consciously experience as little as possible of the treatment or is it the lack of alternative methods?

Funding Problems

Due to the low, inadequate reimbursement for medical abortion with Mifegyne, most physicians and medical facilities licensed to conduct abortions according to section 13 Act on Pregnancy Conflict do not offer this method in the course of the regular reimbursement procedures.

Some 80 % of the women claim reimbursement payments through their Federal States as they are legally entitled to. Reimbursement for medical services is insufficient and, as a result, physicians and medical centers hesitate to offer alternative methods. Therefore medical abortion is not an option for these women.

Considering the legal situation in other European countries and the fact that some Federal States do offer alternative funding, there is no doubt that nationwide, medical services have to be re-evaluated for the benefit of women and to improve health care.

Reports and Recommendations from Work Shops

After intensive discussion of the reports from the four work shops on medical standards, care standards, training and qualification as well as reimbursement and compensation, the participants in the conference agreed to the following concluding recommendations:

For Free Choice and Internationally Accepted Standards

As a drug for medical abortion, Mifegyne has been in use for 12 years in France and now for almost one year in Germany. Pro familia, German Society for Family Planning, has taken this opportunity to host a conference on medical abortion. This conference is also part of a project accompanying the introduction of Mifegyne, endorsed by the Federal Ministry for Family, Senior Citizens, Women and Youth. The conference had the goal to compile experience to date and to assess if quality standards defined abroad could be applied in Germany as well.

The conference, which was opened by Federal Minister Dr. Christine Bergmann, was attended by some 80 physicians as well as staff members from family planning centers all over the country.

The conference provided new impulses for the development of adequate availability of abortion. Experts from France, Austria, Sweden and the United States shared experiences from their countries. International care standards were discussed. Also, the conference discussed how this new method can be included into medical training and how the availability of this method can be maintained or even improved by adequate compensation and a suitable distribution scheme.

Recommendations for Medical Training

Family planning, including the various methods of abortion, have to be part of medical training as well as of the special education for gynecologists and general practitioners.

The current WHO guidelines on counseling on the various methods of abortion are to be adopted.

Physicians carrying out abortions should have acquired good knowledge on family planning during their education and should also have conducted a minimum number of operations as well as a minimum amount of supervision.

Recommendations for Medical Standards

The treatment and the drugs used during treatment should be developed further based on experience and research, allowing more consideration of women's needs. Possible improvements could be

- extending the period of time Mifegyne may be used
- reducing the dosage
- modification of the procedure.

Recommendations for Care Standards

It is necessary to improve communication between the patients and the professionals involved in the treatment. Also, cooperation between professionals involved and their qualification have to be improved.

Regarding the choice between the alternative methods as well as the process of medical abortion, patients and doctors need to be on equal footing.

Women, who after compulsory consultation decide to have an abortion, should have the opportunity for counseling on the variety of methods and on the possibility of early abortion immediately after this first consultation. Easy to follow and thorough information should be available.

We have to make sure of the availability of constant care and counselors who may be contacted by phone at all times.

There has to be an exchange of experiences between physicians and counseling centers as well as further training for both groups on a regular basis.

Recommendations on Compensation for Medical abortion

The current issues of funding medical abortion and distribution of Mifegyne in Germany were also discussed at this conference. As Mifegyne's German distributor has given up its marketing rights, the product will probably be no longer on the market by the end of this year. This would be a dramatic set back for all those striving to maintain and to extend women's right of free choice. Political initiatives securing the distribution of Mifegyne on the legal level or making existing distribution regulations less complicated will be appreciated. The following measures are crucial:

We are calling upon the Valuation Committee to agree on an adequate classification of medical abortion.

We are asking the government to consider if in those cases, where the Federal States cover the expenses for abortion, the subordination of compensation for all methods of abortion to EBM[7] may be lifted. This could be done according to the cost-effective regulations already existing in Bavaria, Baden-Württemberg and Schleswig-Holstein.

The participants of the conference call upon the Federal Ministers Dr. Christine Bergmann (Families, Senior Citizen, Women and Youth) and Andrea Fischer (Health) to continue their commitment to Mifegyne, to use all of their political influence in this matter and to encourage the Valuation Committee to agree to adequate compensation. Also, lawmakers of all parties are invited to join in a bipartisan Coalition of Good Sense on behalf of women to guarantee them free choice among the methods of abortion.

[7] EBM, i.e. Einheitlicher Bewertungsmassstab, is a catalogue of criteria of all conceivable medical services. Each of them is rated at a certain score of credit points, which are the basis for the compensation a doctor will receive from statutory health insurance.

Postscript

Mifegyne is still available in Germany. Women in Germany will remain able to choose medical abortion. A resolution on higher compensation for medical abortion passed by the Valuation Committee will be in effect by 1 July 2001 (cf. footnote 6, p. 13)

Speakers, Hosts of Work Shops

Dr. Elisabeth Aubény, Hôpital Broussais, Paris, France, M.D. specialized in Gynecology, created one of the first centers in Paris for family planning and pregnancy termination. In 1983, she organized the Family Planning Center of Broussais Hospital which became a pioneer center for clinical trials using RU 486. President of the International Federation of Health Professionals in contraception and abortion and board executive member of the French Association of Family Planning Centers, the NAF equivalent for France, executive member of the European Society for Contraception, President of the Scientific Committee of the year 2000 congress of the ESC and Vice President of the French College of Gynecology of Paris, Île de France.

Dr. phil. Ulrike Busch, Executive Director of Balance Family Planning Clinic, Berlin, Germany, sexual counselor and family therapist, until May 2000 member of pro familia board of executives, advisor to pro familia in the field of family planning etc.

Dr. med. Christian Fiala, Intern at the Gynecology and Obstetrics Department at Korneuburg Hospital near Vienna, Austria. Education in general medicine in Austria, Thailand and France. Diplomas in psychosomatic medicine and tropical medicine, commitment to family planning, author of a book on HIV/AIDS as well as author/co-author of publications on contraception and pregnancy termination.

Dr. med. Gabriele Halder, gynecologist in private practice in Berlin, Germany, chairperson at Balance Family Planning Clinic, Berlin.

Hanna Staudt-Hupke, Executive Director of pro familia branch in the State of Bremen, Germany, social scientist.

Elfie Mayer, public relations coordinator at Family Planning Clinic Hamburg, Germany, registered nurse, active in pro-abortion movement since 1980, co-founder Family Planning Clinic Hamburg in 1982, co-author of »Traurig und befreit zugleich – Psychische Folgen des Schwangerschaftsabbruchs (Sad and Relieved at the Same Time – Psychological Effects of Abortion)« (Hamburg 1985).

Dr. Ingrid Oestlund, physician at Kvinnokliniken, Orebroll, Sweden. Specialist in Obstetrics and Gynecology. Since 1988, head of maternal health care including family

planning in the county of Oerebro. Secretary in the family planning group at Swedish Society of Obstetrics and Gynecology.

Klaus Riemann, lawyer, Executive Director of GESOMED Society for Sociological Research in Medicine, Freiburg, Germany. Some 100 research projects in fields as promotion of good health/addiction, communal health research, self-medication, quality of life, scientific support of model projects, training and advisory service in issues as evaluation and quality standards.

Prof. Dr. med. Hans-Georg Siedentopf, formerly Managing Director Outpatients' Dpt. Universitaetsfrauenklinik (University Gynecological Hospital) Frankfurt am Main, Germany. President of pro familia in the State of Hesse for 21 years, member of the German Society for Gynecology and Obstetrics, of the Society for Psychosomatic Gynecology and Obstetrics as well as of the Professional Association of Gynecologists.

Dr. med. Ansgar Pett, gynecologist in private practice, Berlin, Germany, President of the Berlin chapter of the Outpatient Surgery Association, member of the professional Association of Gynecologists and delegate of the Kassenaerztliche Vereinigung Berlin.

Elke Thoss, Executive Director of pro familia, Frankfurt am Main, Germany, sociologist, consultant for international organizations, i. e. International Planned Parenthood Federation (IPPF), United Nations Population Agency (UNFPA).

Dr. Beverly Winikoff, Population Council, New York, USA, is responsible for development and management of the Council's reproductive health acitivities. She directed the Council's studies on mifepristone in India, Cuba, China, Vietnam, Tunisia and Turkey. Focus on issues of reproductive choice, contraception, abortion and women's health. Main interest in issues surrounding the abuse, misuse and non-use of medical technology as these phenomena impact on women's health and autonomy. Dr. Winikoff graduated from Harvard University magna cum laude, M.D. from N.Y. University, M.P.H. from the Harvard School of Public Health. Prior to joining the Council in 1978, she was Assistant Director for Health Science, The Rockefeller Foundation.

Select Newspaper Articles on the Conference

Berliner Morgenpost
10/26/2000

Pill Controversy

Politicians looking for a way to keep the abortion drug Mifegyne in Germany

By Lars-Broder Keil

The debate on the abortion drug Mifegyne continues, as the company distributing the drug in Germany has announced it is taking the product off the market. The joint Valuation Committee of doctors and health insurance refuses to raise compensation for doctors conducting medical abortion. Currently, doctors receive an average 300 Marks for medical abortion. That's why many physicians rather offer the surgical method, which brings in twice as much. Now, a startled Schroeder Administration is desperately trying to find a solution that would keep women able to choose between surgical and medical methods of abortion.

Deputy Health Minister, Christa Nickels, wants the States to show more responsibility. According to the Act on Aid for Needy Women Having an Abortion, the States help out in case of social hardship – that is 70 % of all abortions. 25 per cent of the women pay for the abortion by themselves, only five per cent of the cases are covered by the health insurance system. Trouble is: The law forces the States to base their payments for the Mifegyne method on the classification that doctors and health insurance have agreed on. Schleswig-Holstein and Baden-Württemberg do not follow this regulation and pay some 500 Marks per treatment with Mifegyne. To Nickels, this could be a model for the future: »The use of the abortion pill is subject to special regulations and consequently enjoys a special privilege. That would justify a higher remuneration through the States«, the deputy minister told Berliner Morgenpost. It would be easier if the Valuation Committee showed some flexibility. So far, the ministry's efforts have not led anywhere: »We do not have any supervisory authority over the Committee«, Nickels regrets. That is why the Green Party's specialist on feminist politics, Irmingard Schewe-Gerigk, wants legislature to pass a new bill on doctors' compensation. Green Party whip Katrin Goering-Eckardt suggested amending the Act on Pregnancy Conflict to allow for possibilities for follow-up treatment and compensate treatment both prior to and after abortion.

The Social Democrats reject both initiatives. Deputy party whip Gudrun Schaich-Walch fears that this would create a precedent overturning the system and would make the government susceptible to blackmail. Before making hasty decisions, Schaich-Walch argues, the causes of the current developments and the patterns of distribution need to be analyzed very carefully. During the second quarter of the year 2000, the number of medical abortions had increased by 50 %, Schaich-Walch claims.

It is unlikely that doctors and the health insurance system will agree on higher compensation. On the one hand, discussions on a new set of criteria on the treatment of outpatients are deadlocked. On the other hand, the health insurance system doesn't see

any need for action. »There is no such thing as inadequate provision. The marketing company is taking the drug off the market for economical reasons. There simply is no demand for the pill«, says Christine Richter of the Bundesverband der Betriebskrankenkassen (Federal Association of Company Health Insurance Schemes). Lobbyists on behalf of the doctors also fear that preferential treatment of gynecologists might cause an uproar among other specialists. That is why Juergen Bausch, the Kassenaerztliche Bundesvereinigung's expert on prescription drugs, defends low compensation: »There are no extra costs for medical equipment or treatment rooms.«

The current regulations do not compensate the enormous amount of time the treatment requires, the doctors argue. Two to three days after taking the pill, the patient has to come back to the doctor's office and take another drug causing the body to expel the embryo. After that, women need special attention for several hours. Check up appointments follow. Many doctors do not have the infrastructure they need for this kind of treatment. Also, there are special regulations for the distribution of the drug that need to be observed. Mifegyne is distributed directly to doctors and clinics. And that makes safety measures necessary.

The FDP (Liberal Party) wants to get rid of this method of distribution. They want Mifegyne to be sold at pharmacies like other prescription drugs. Also, compensation for abortion should be taken out of the cost control budget for doctors, demands health expert Detlev Parr. Instead, he calls for fixed rates of compensation and wants to introduce a bill for his party in the Bundestag.

All this doesn't help the Femagen company, which wants to quit selling the drug by the end of this year. Since Mifegyne was introduced in November of 1999, 400 to 600 packs were sold every month – only one third of what the company had expected. During the first quarter of 2000, only 4.5 % of the abortions conducted in Germany were done medically. In France and Sweden about 35 %. As this situation is not likely to change, the company has decided to give up their marketing rights for Mifegyne. What remains is the economic loss, which adds up to almost 2 million Marks.

Der Tagesspiegel
10/28/2000

The Abortion Pill's Future
Come off too early
It took a long fight to introduce the pill. Just one year later, the fighting continues – to make it stay.

By Adelheid Mueller-Lissner

In France, 700,000 women have been through medical abortion with the drug Mifegyne. »To us, this method has become a routine years ago«, says Paris gynecologist Elisabeth Aubény. She is the founder of the family planning center at Hôpital Broussais, where early clinical experiments with the »abortion pill« were carried out in the 1980s. And today, she will talk about French experiences at the Conference on »Medical abortion with Mifegyne«, held by the family organization pro familia in

Berlin. Almost one year after the drug was introduced to Germany, the conference is taking place at a time that Mifegyne is under discussion again. The reason is the announcement of Femagen, the distributing company, that it would take the drug off the market due to sales problems. The sale of the drug is subject to strict regulations, so that purchasing the drug from international pharmacies is not an option. Thus, Mifegyne will no longer be available in Germany by the end of this year, pro familia warned prior to the conference. »But we will not cease to fight for the women's right of free choice«, pro familia's executive director, Elke Thoss, said this Friday in Berlin.

»It's not just the doctors' greed«

Not only gynecologists but also pro familia claim that inadequate compensation is the reason why the this new method has spread so little during the past year. At the Balance family planning clinic in Berlin, a total of 170 abortions have been conducted with Mifegyne since December 1999, says manager Ulrike Busch. However, because of problems with compensation, they gave up offering this method to women who are entitled to reimbursement from their health insurance. »This is not just about greedy doctors but a serious problem. And we want to the politicians to attend to it.«

Compensation for the services of the health insurance system is regulated by the Valuation Committee of the Kassenaerztliche Bundesvereinigung. Right now, according to Busch, an abortion under general anesthesia is valued at 649 Marks, surgery with local anesthesia at 373 Marks and medical abortion at 279 Marks. The drug alone costs 160 Marks.

Experts say that these differences in compensation are not justified. »Medical abortions call for a considerably greater need for counseling«, says Christian Fiala. He works at Korneuburg Hospital near Vienna, which is the first institution in the German-speaking area to use Mifegyne. Since January 1999, they have had experience with 800 medical abortions. »More than 90 % of the women would do it again«, Fiala says.

Gynecologist Ingrid Oestlund from Sweden agrees. People had been skeptical at first, she says, but now more than half of the abortions up to the ninth week were done with the drug. To Elisabeth Aubény, the fact that in France there is no increase in the total number of abortions since medical abortion was introduced is particularly important. In the United States, where abortion issues are discussed much more fiercely than in Europe, the drug is registered only since 28 September 2000. Regulations for the use of the drug are – and that, too, is very American – much more liberal. The permission to use the drug is not limited to especially trained doctors or certain institutions.

Pro familia is now calling upon the responsible ministers, Bergmann and Fischer, to use their political influence and have the Valuation Committee agree to adequate compensation. However, it is quite controversial if this committee should be put under too much pressure from outside. Ulrike Busch, too, believes that the ministries' influence is limited. Meanwhile, the FDP (liberal party) has started a parliamentary initiative to make the drug's distribution easier.

Reservations about the new method

Apart from the tiresome question of costs, many doctors seem to have reservations towards this comparatively new method. Even though the gynecologists' association

stated as early as 1993 that the drug, which at that time was still called RU 486, was »a more gentle method of abortion and to be preferred to surgery«, the medical method (which can only be conducted until the 49th day after the last period) is neither easy nor painless. Also, many gynecologists believe that the method causes more psychological stress. Supporters say the big advantage of the medical method is that women play an active role and consciously experience every step on the road. Speculates Christian Fiala on the motives of some of his colleagues: »Maybe some doctors prefer their patients under general anesthesia, so they won't have to talk to them.«

Sueddeutsche Zeitung
10/30/2000

»Woman's Moral Property«
Doctors discuss Mifegyne abortion pill

One year after its introduction to Germany, abortion pill Mifegyne's future is looking bleak. To stop the distributing company, Femagen, from taking the drug from the market by the end of the year, pro familia hosted an international conference this weekend. Doctors from Europe and the United States talked about their experiences with Mifegyne in Berlin this weekend.

Beverly Winikoff of New York's Population Council talked about the situation in the United States. Doctors have conducted studies among American women, asking them why they chose either the medical or the surgical method of abortion. »Women choosing Mifegyne consider surgery to be an intrusion into their privacy«, Winikoff says. Others wanted to »delegate« the process to a doctor instead of consciously experiencing the abortion. These women decide to have a surgical abortion in general anesthesia.

»Antiquated understanding of woman's role«

Viennese gynecologist Christian Fiala believes, there are no urgent objective reasons to stop the distribution of Mifegyne in Germany. Even the argument of the great efforts it takes to make it available – distribution of the abortion pill is heavily restricted in this country, which makes it very expensive – is a poor excuse, he says: »Within months, Viagra was available to men all over the world. Mifegyne, which enables women to make a self-determined choice, is bound to fail because of an antiquated understanding of woman's role.«

»Mifegyne is women's moral property«, Elisabeth Aubény, a gynecologist from Paris and member of the European Society of Contraception, agrees. Since 1992, 700,000 abortions with Mifegyne have been conducted in France. However, the drug is not the French specialty many people in Germany think it is. Not only other European countries but also China, India and Tunisia use Mifegyne on a large scale.

In Sweden, the pill was certified in 1992. Some 60 % of early stage abortions are conducted medically today. »Mifegyne is not only more gentle on the women because it

doesn't involve surgery, most women in Sweden also think that the method is more comfortable«, says Ingrid Oestlund, member of the Swedish Gynecology Society.

As sales are slow, the German distributor wants to take the pill, which has been available in Germany since November 1999, off the market. This year, only five per cent of abortions were conducted with Mifegyne. Doctors are not interested because of inadequate compensation, they say. Abortion with Mifegyne is valued at 279 Marks, whereas surgical abortion brings in 649 Marks.

»The conference showed that in Germany the issue of abortion is still an ideological battlefield«, sexual counselor Ulrike Busch summarizes her impression of the gathering.

Further Results

Further Results

One important objective of the project was to enable women as soon as possible to make their own self-determined choice based on thorough information and their own individual situation.

During the project, several training seminars for counselors and doctors were conducted. Also, we compiled and distributed information brochures for women in German and a variety of foreign languages.

Information for Clients

To help women to decide on a suitable method of abortion, an information brochure was compiled indicating the effectiveness, the risks and side effects, as well as contraindications, the time frame and the procedures (cf. appendix). Beside a German version (200,000 copies), a Turkish and a Serbo-Croat version were published (20,000 copies each). They were distributed to all pro familia facilities, to all certified pregnancy conflict counseling centers as well as interested medical facilities in early 2000.

In May 2000, the general assembly of pro familia members suggested offering English, Russian, Spanish and French versions as well and making them available to pro familia centers and other institutions. The translations were done by professionals and then sent to pro familia's State branches as well as European partner organizations to have them revised by qualified native speakers.

Further Education

The seminars that were offered during the project had the objectives of

- improving the counselors' competence with regard to the extended options of abortion methods,
- passing on know-how and improving the competence of medical staff and counselors and
- improving cooperation between counseling centers and medical facilities at local and regional levels.

Between January and March 2000, there were ten seminars for counselors and employees of medical facilities. There were a total of 331 participants. Seminars were held in Rendsburg (01/19), Schwerin (01/20), Magdeburg (01/21), Leipzig (01/22), Münster (03/09), Duesseldorf (03/10), Mainz (03/11), Nuernberg (03/13), Stuttgart (03/14) and Goettingen-Reinhausen (03/15). There are more details available about nine of these seminars with a total of 239 participants. According to these data, 21 %

of the participants were physicians, 77 % were counselors. The participants came from the following institutions:

Institution	Number of participants	Proportion
Arbeiterwohlfahrt	17	7 %
Caritas, other Catholic institutions	11	5 %
German Red Cross	10	4 %
Diakonie, other Protestant institutions	38	16 %
hospital / own practice	38	16 %
pro familia	55	23 %
state / communal counseling centers	44	18 %
others (individual institutions, self-help groups)	26	11 %
total	239	100 %

The seminars were divided into three sections:

Section 1: current medical developments

- information on procedure and organization of abortion with Mifegyne
- practical experience from Korneuburg Hospital, Austria, where abortions using Mifegyne have been carried out since 1999, also select specialist literature
- peculiarities regarding abortion with Mifegyne, both from the medical perspective and the institution's point of view.

Section 2: experiences from counseling and care in Austria

- peculiarities regarding abortion with Mifegyne from the patients' and from the counselors' perspective
- the patients' need for information in order to be able to make a decision (demands for counselors and medical staff).

Section 3: special aspects of counseling and medical treatment in Germany

- how does counseling according to section 5 Act on Pregnancy Conflict change with regard to the introduction of Mifegyne?
- what problems (legally and financially) arise for patients, counseling centers and medical practice?
- what conditions have to be created on the local level to make choices available to women? (exchange of experience)

The seminars were based on papers, role play (optional) and discussions.

Participants were particularly pleased to receive information on medical aspects of treatment with Mifegyne as well as issues of counseling and care during treatment. The desire for standards in counseling and care played an important role.

Discussing issues regarding medical abortion and mandatory counseling according section 5 Act on Pregnancy Conflict in connection with section 219 Penal Code (Abortion Counseling Act) as well as other structural conditions in Germany turned out to be more difficult (section 3). Problems were

- the lack of experience with counseling at the time of the seminars
- imponderables concerning compensation (no standard regulations so far)
- the various ways counselors of different institutions and doctors perceive their professional roles; however the seminars made a considerable contribution in attempting to define the roles that doctors, counselors and medical staff in medical facilities as well as counselors in counseling centers actually play. Also, there were very useful ideas about how to create a better network and of offering internships at the various institutions.

Some issues discussed were:

- financial compensation for doctors
- certification of prostaglandin in connection with medical abortion and how it should be administered
- letting the patient be in charge
- counseling on methods of abortion at pregnancy conflict counseling
- home pregnancy tests
- nursing during medical abortion
- minor patients
- networking and cooperation between doctors and counselors
- other persons accompanying the patient to the abortion
- women's fears and insecurities in the course of the treatment.

The seminars were evaluated with the same method pro familia always uses (cf. Riemann/ Lutz: Qualitaetssicherung in der Fort- und Weiterbildung, published by pro familia, Frankfurt am Main, 1999). Evaluation showed that the learning effects of these seminars were outstandingly good.

MEDICAL ABORTION

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